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JOURNAL OF THE KANSAS MEDICAL SOCIETY

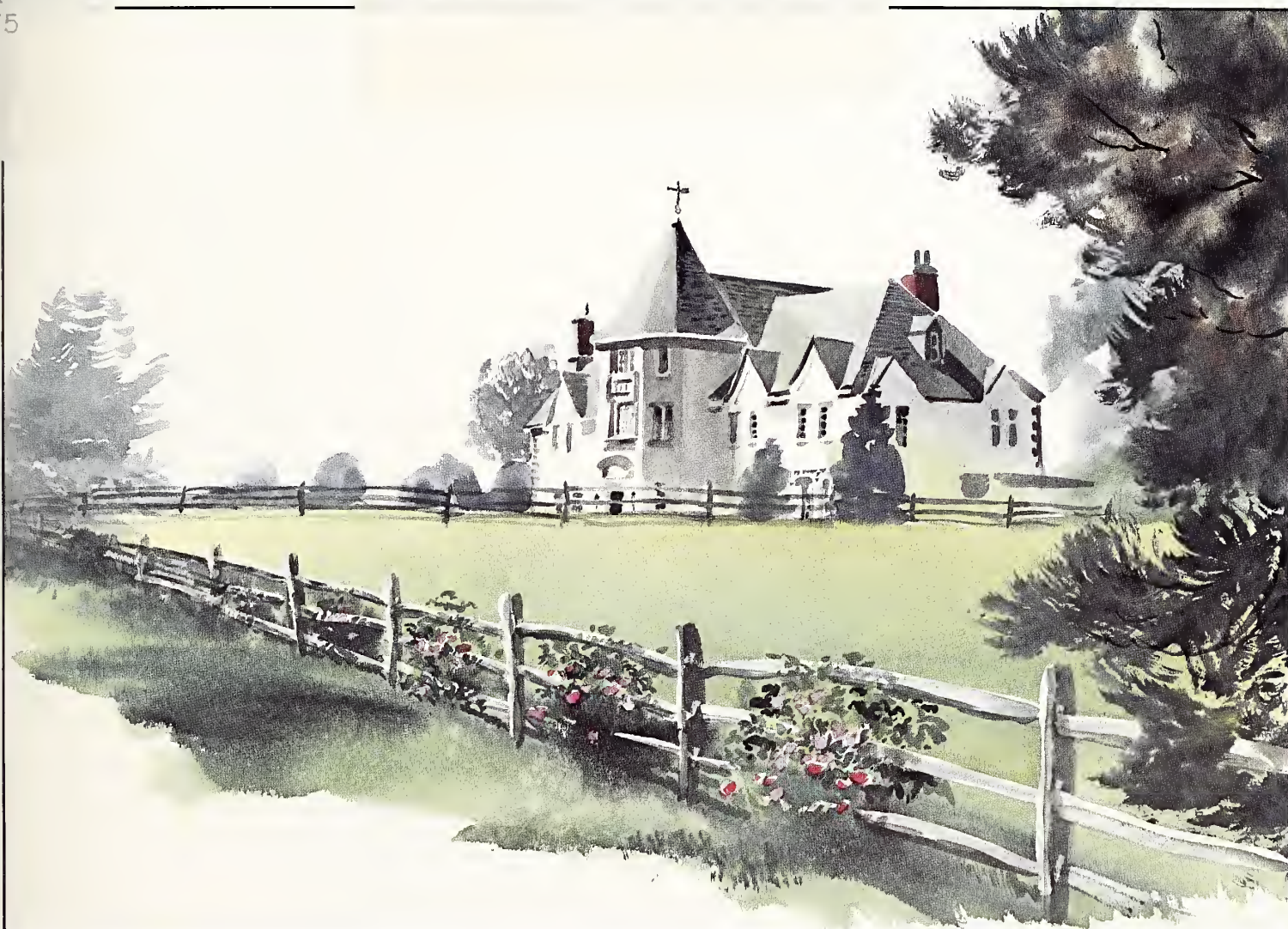
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Journals

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Adult Respiratory Distress Syndrome Lobbying, Kansas Style



KANSAS MEDICINE

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ABOUT OUR LOGO

In January 1935, a new logo appeared on the cover of KANSAS MEDICINE for the first time. This device represents two stethoscopes: the original monaural type as used by Laënnec, and the modern binaural variety. The logo was designed expressly for KANSAS MEDICINE by renowned graphic designer Bradbury Thompson, a native of Topeka and friend of two former editors of the journal, Dr. W.M. Mills and Dr. Lucien Pyle. As another former editor, Dr. Orville R. Clark, wrote in January 1955, the logo "has become as much a part of the journal as any of the features on the inside and is something which is ours alone."

January brings the reconvening of the Legislature to Topeka. Whether or not any notable changes go on downtown this year, there will be some changes out on a hill on the west side of town, in the mansion known as Cedar Crest.

The mansion sits high on that hill, appropriate to its baronial architecture. To the east, at the time it was built, was the Page farm, now covered by homes and the Presbyterian Manor retirement community. To the west were the offices, hospital and children's home of the Knights and Ladies of Security, an effort to provide cradle-to-grave insurance that eventually led to the more profitable Security Group of Companies. (That piece of real estate is now occupied by the Menninger west campus.) But mainly the hills are remembered for wonderful sledding in the winter, if sledders could get someone to take them — and their sleds — out there. It was, after all, a long way out in those days.

The mansion's story is well known. Cedar Crest was built by Frank P. McClennan, who had come to Topeka in 1885 after working in Emporia (where anyone seeking journalistic success touched base at some time) and had bought the *Topeka State Journal* (now the *Journal* half of the *Capital-Journal*). He built the home in 1928, but died only five years later. His widow continued to live there until her death, which regrettable event (she was a nice lady) presented the state with something of a problem.

Mrs. McClennan willed the mansion and its grounds to the state to be used as a Governor's residence. But the Legislature dragged its feet, largely because of the expense that would be required to alter it for state functions. After the usual Kansas hassle, scaled-down plans were approved, the home was accepted by the state and, in 1962, the Carlins became the first First Family to occupy it.

This time it will be a bit different, however. The campaigns had hardly begun before various jokes, soon tiresome, developed about the redecorating that would be required, should a woman be elected governor. And in fact, for the first time, there *will* be a woman in charge — politically as well as decoratively. It will be interesting to see what eventuates, but one thing is certain: the redecoration will be in the personnel and events more than in wall colors, drapes and upholstery.

Point of View

Sometime in our dark past, when religious sensitivities did not inhibit references to gods and such in schools, we learned that the month of January was named after Janus, the Roman god of doors, whose two faces symbolized the view behind us and the view ahead.



We have reached the point when we find ourselves increasingly beholden to old Jan. This stems from the fact that our view ahead is not only shorter but more certain, while the increasingly long view back, in the form of personal history, invites observations, generally of more interest to the observer than to anyone else. Such observers have the benefit of cornering younger audiences who, not having been there, can't question the accuracy of the tales of the past. (Devotees of oral histories: be warned that recalled events are likely to have happened in quite a different manner — or not to have happened at all.)

This looking-both-ways seems an inevitable accompaniment of aging and is probably the major cause of conflict between the ages — the elders clinging to what they have known out of reluctance to give it up, the younger folks seeking to establish their own. Such thoughts stemmed from the information that a grandson was considering a career in medicine. Admittedly, the matter came up not because of any direct request on his part for advice but, since it was there, it seemed to call for some sage observations. We confess we found the self-imposed assignment more difficult than we had expected because, we presume, of a true uncertainty of what the future holds for medical practice. Oh, there is no lack of opinions — from the ominous assurances that the end of the medical world is at hand to the promise of even greater victories just ahead.

It could hardly be otherwise when we consider the events of the past century in medicine and in the socioeconomic world with which it has become melded. This brought to mind another question: Would the medical parents of a prospective medical student offer different comments on those events and the possibilities for future practice than would the grandparents? Would the relatively short period of a generation — short in

the long age of medical service — make a difference in the attitudes of the two? One would be inclined to say that if any period of medical history could accomplish such a change of feeling, the years just past and upon us now would do it. And again, one wonders whether that interpretation is justified or is just the arrogance of belief that *we* have experienced events of greater magnitude than have our predecessors.

It has been reported not infrequently that medical parents are increasingly advising their children not to go into medicine — at least, not encouraging them in that direction. Certainly, there has never been a time when the promise of medicine for dramatic accomplishments was greater (there's that old arrogance of presence again), but this and numerous influences have changed the form of medical practice to one which alienates many and discourages even the optimistic. The physician is, on the one hand, pleased to be able to offer such actual and promised benefits but, on the other, resentful of the changes in practice conditions which are part of it.

So the shifting tides have washed away some of our cherished self-image. The medical persona is increasingly suspect in the eyes of the public criers. The physicians are angered at the situation because they, from the beginning, have been motivated by a desire to provide the basic form of medical service and are reluctant to permit any of it to be sacrificed in the name of socioeconomic necessity. Thus, the profession is subjected to a dichotomy of purpose — to promote its values to the coming generations or discourage them because of their own sense of loss.

The only solution we have personally been able to reach (and we have advanced it before) is to recall that those coming on have grown through changes as great as we have been through during our practice days. For all the fidelity to certain academic basics, they will be taught differently and will certainly practice in a different world. Medicine is much more of a social tool than it was a couple of generations ago, and even the most specialized of physicians must look beyond the confines of practice for ways in which to provide benefits to society other than those professional services. The young may not be smarter, but they will do better at it than we have. **D.E.G.**

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UKSM-W: Past, Present and Future

The development of the clinical campus of the University of Kansas School of Medicine at Wichita (UKSM-W) has been a story of success. In the early 1970s, when there was pressure on state medical schools to expand their student enrollment, a number of geographically remote campuses were established. Many of these endeavors are now in some jeopardy, as the national enrollment of medical students continues to fall from the peak numbers of a decade ago. Fortunately, no such concern for survival looms before our Wichita campus, due in large part to the superb leadership from both the University of Kansas and the Wichita community. The school has been particularly fortunate to have had the guiding hands of Dr. D. Cramer Reed as the founding dean, and now we have reached the end of the inspired steerage of Dr. William J. Reals.



Today, UKSM-W fully occupies its campus headquarters building and has fully approved clinical programs in the community hospitals and the Wichita Veterans Administration Hospital. One hundred medical students and 220 residents receive their educational training solely through the Wichita campus. The development of the Wichita Center for Graduate Medical Education (WCGME) has been a major achievement of national importance. WCGME has become a model for others to follow in its now-functioning role of providing a university umbrella for all of the Wichita community-based residency programs.

As successful as this campus has become, however, an academic institution must never rest upon its laurels. Such an attitude will surely place educational achievements in the past tense. And so it is time for a new beginning, a new voyage from the safe harbor of a committed medical community. Where are the areas of need to which this voyage should be directed? It seems to me that there are at least four concerns in need of attention from this community-based campus.

Today's medical schools must work with their communities in developing model programs in preventive medicine and public health. Our physicians of tomorrow will face increasing expectations from their patients for advice and leadership

"There are at least four concerns in need of attention from this . . . campus."

in health maintenance and disease prevention. Access to basic health care needs by our citizens deserves the involvement and commitment of our state-supported medical schools.

Educational interchanges must be better established between the medical school and its students and the practicing medical community. The medical preceptorship program, for which Kansas has received national recognition, must be strengthened and expanded to bring our students and residents in better contact with the educational opportunities outside of our major metropolitan hospital settings. In addition, we need to provide opportunities for Kansas physicians to improve and update their skills by developing refresher courses and clinical traineeships at the university campus.

The medical school must be the beacon that attracts the students of today towards membership in the medical profession of tomorrow. Starting at the high-school level, the clinical faculty must help and encourage the young people in our state to consider and commit to a career in medicine in order that our physician manpower needs will be met.

UKSM-W must continue to explore new and innovative programs which will promote education and retention of primary care physicians for Kansas. The Primary Care Bridging Plan, now operational, must be nurtured and supplemented with additional financial incentives and other inducements which will encourage our medical students to enter into a long-lasting association with the primary care disciplines.

In all of these new areas of emphasis, the medical school will be well advised to remember the

(Continued on page 24.)



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The National Practitioner Data Bank

WAYNE T. STRATTON, J.D.,* *Topeka*

In a litany which is becoming increasingly familiar, Congress passes a law designed to solve a societal problem, empowers the bureaucracy to write regulations, and then finds the remedy may be worse than the complaint. Time will tell whether our nation's hospitals and medical licensing agencies were really failing to obtain meaningful information about the credentials of health care providers, or whether Congress again has acted precipitously.

Physicians are justifiably anxious about the implications of a national data bank, since it is easy to visualize very real potential adverse consequences of having one's record available for scrutiny. The really unsettling aspect is that much of what is reported may occur without the involvement or consent of the physician. The "consent



Is the refund of a fee a reportable event?

to settle" clause in malpractice policies issued in Kansas was eliminated in 1976. While many companies will confer with a physician before settling, they are not so obligated.

Recently a clinic was sued in Small Claims Court for an amount less than \$100. A patient became dissatisfied, felt that the treatment was improper and asked for refund of the fee. Business considerations would certainly mandate an economic resolution of such a claim. Unfortunately, the physicians had to be told that the expedient resolution of the complaint would lead to the obligation to report the payment to the National Practitioner Data Bank.

Sec. 60.7 of the Data Bank Title IV Regulations provides that any person who makes a payment in settlement of a claim for medical malpractice must report the same to the licensing board. "Medical malpractice action or claim" is defined to include a written claim demanding payment for a health care practitioner's provision of or failure to provide health care services.

Ironically, the regulations provide that the waiver of an outstanding debt is not construed as a "payment," and is not required to be reported.

While these regulations are currently being challenged in a lawsuit, physicians should be aware of the current implications of returning a fee to a dissatisfied patient.

*KMS Legal Counsel.

Comments appearing herein are not intended as a substitute for legal analysis or advice. Answers to legal questions depend largely upon the particular facts of a case. The reader is urged to consult an attorney for answers to specific legal questions.

These comments do not necessarily represent the views of KANSAS MEDICINE, or the Kansas Medical Society. For further information, contact Mr. Stratton, 515 S. Kansas, Topeka, KS 66603, 1-800-332-0248.



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KMS Auxiliary Celebrates the Past and the Future

Dear Physicians:

As I think about what I want to convey in this message, it seems appropriate to review the goals and to rejoice in our accomplishments. As I have traveled through Kansas, I have found each county auxiliary is doing well. Most of their activities continue to focus on helping others. This includes raising money for our own AMA-ERF, working in cooperation with local health projects and helping the needy and the elderly.



Last August, we responded to the AMA Political Affairs Division's request to write and call members of Congress and ask them to support an increase in excise taxes on alcohol and tobacco. Currently, our legislation chairman, Nancy Craig of Newton, is working with Chip Wheelen of the KMS staff on plans for a "take-your-legislators-out-to-dinner night" on February 12, in Topeka. A registration form for this purpose is below. Please plan to come and be a host and hostess.

Sherry Hyszczynskyj, of Topeka, our AMA-ERF chairman, donated prizes for AMA-ERF mini-raftles at county auxiliaries, worked on sharing cards, and is currently planning an auction in May at our annual meeting. Your donation of auction items would be most appreciated.

This year, one of our health projects is to introduce Dr. Jay Schukman's KMS-KBA program to county auxiliaries. This substance-abuse teaching program was initiated last year by the president of the American Medical Association and the president of the American Bar Association. A physician and a lawyer pair up to teach junior high students about substance abuse. The physician describes the physical effects of drugs and alcohol, and the lawyer discusses the legal consequences. If you are interested in being a part of this program, please contact Dr. Jay Schukman of Great Bend at 316-792-5341, or our health project chairman, Glenda Schmidt of Salina, at 913-827-2229.

And finally, if your spouse is not yet a member of the medical auxiliary, please encourage him or her to join. Our membership chairman, Carolyn Harrison of Wichita, has designed a very comprehensive postcard for membership recruitment and information. We would love to send you some. Please ask. Carolyn's telephone number is 316-634-0613.

Wishing you a successful 1991!

Joying Jee

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February 12, 1991

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Adverse Reactions: (percentage of patients)

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- Stevens-Johnson syndrome, toxic epidermal necrolysis,

and anaphylaxis have been reported rarely. Anaphylaxis may be more common in patients with a history of penicillin allergy.

- Gastrointestinal (mostly diarrhea): 2.5%
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertension, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1% and, rarely, thrombocytopenia and reversible interstitial nephritis.

Abnormalities in laboratory results of uncertain etiology

- Slight elevations in hepatic enzymes.
- Transient lymphocytosis, leukopenia, and, rarely, hemolytic anemia and reversible neutropenia.
- Rare reports of increased prothrombin time with or without clinical bleeding in patients receiving Cecclor and Coumadin concomitantly.
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Brief, concise **articles** are preferred; an ideal manuscript will not exceed five double-spaced pages. All material will be edited by the editorial staff to assure clarity, good grammar and appropriate language, and to conform to KANSAS MEDICINE style and format. When feasible, material may be condensed.

The author will be asked to review the **galley proof** prior to publication. Although editing and proofreading will be done with care, the author is responsible for accuracy of material published. The galley proof is for correction of **ERRORS**; rewriting of material *must* be done prior to submission. Authors are urged to check manuscripts and galley proof carefully for errors that could result in inaccurate information.

Drugs should be referred to by generic names; trade names may follow in parentheses if useful. All **units of measure** must be given in the metric system.

KANSAS MEDICINE will print a maximum of **ten references**. All references should be keyed with superscripts in the text in the order cited. If more than ten sources are cited, readers will be referred to the author for the complete list.

Illustrative material must be identified by its referral number in the text and be accompanied by a short legend. **Photos** should be black-and-white glossy prints. **Tables** should be self-explanatory and should supplement, not duplicate, the text.

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A **reprint** order form with a table showing estimated cost will be sent with the galley proof. Reprints must be ordered by the author through KANSAS MEDICINE, and will be billed to the author following shipment.

Kindred Spirits

Happiness for genealogists is finding a current representative of a family line by tracing the tracks by which he or she got here. Though the line may be devious, collateral is a term as dear to them as to a banker. And when common points of interest, intellect and accomplishment are observed, it is a cause for celebration. Consequently, this celebration is prompted by the fact that Joseph E. Sawtell, M.D., who was 44th in the line of presidents of the Kansas Medical Society, was an antecedent of our current president, Joseph C. Meek, Jr., M.D., who is 128th in that distinguished group.

The 44th president of KMS was a relative of the 128th — and current — president.

To be a little more specific, Dr. Sawtell was a son of W. E. A. Sawtell, and his mother was formerly a Meek and sister of our Dr. Meek's great-grandfather. In what we offer as a suitable classification, this makes Dr. Sawtell and his current relative first cousins twice removed (and any objections to these genealogic calculations can be forwarded to Dr. Meek).

Dr. Sawtell was born in 1859 in McMinn County, Tennessee, which was apparently well supplied with Sawtells and Meeks. He was educated in the public schools and came to Kansas as a young man, staying first with his uncle, W. E. A. Meek, who had come to Hope, Kansas, as a Presbyterian elder. Dr. Sawtell studied at Maryville College and taught school for a year before entering the College of Physicians and Surgeons in Baltimore, from which he graduated in 1886. The young doctor settled first in Gypsum City until 1898, then took postgraduate work in otorhinolaryngology and moved to Kansas City, Kansas to pursue that specialty.

Dr. Sawtell represented a group, still extant, that maintained a form of divided state loyalties, living continually on the Kansas side of the state

line but practicing on the Missouri side. (After all, when there is a strong west wind, the KUMC-KC leans into Missouri.) His practice locations are recorded, in part at least, in the *Journal of the Kansas Medical Society*, vol. 7, which advises: "Announcement. Dr. Sawtell announces the removal of his office from the Rialto Building to rooms 705-706 Bryant Building, Corner Eleventh and Grand Avenue. Home phone, Main 5787."

Whatever his location on the Missouri side, his professional loyalties remained firmly in Kansas. He was a member of the Wyandotte County Medical Society, the Kansas Medical Society and the American Medical Association, and served on the Board of Examination and Registration for Kansas. Dr. Sawtell was president of the College of Physicians and Surgeons of Kansas City when it was merged with the Kansas University medical department to become the University of Kansas Medical School, and he was the first chair of the Department of Rhinology and Laryngology there, serving until his death. He was a co-editor of the *Journal* for several years prior to his election to the presidency of the Kansas Medical Society for the 1908-9 term.

On graduation from medical school, Dr. Sawtell married Gertrude Smith of Clay County, and they had three children. The medical genes skipped

Joseph E. Sawtell, M.D.



a generation but gained strength in the next, which produced one physician, Dr. James Sawtell, who is still living in San Francisco. (The Meeks had to wait until our own representative arrived, but he has provided, with help, one nurse.) In passing, it should be noted that Dr. Meek has divided citizenship as to birth. He was born in Sabetha, since that was where the hospital was, but the family lived in Hiawatha, so that was home to him. His father was proprietor of the still-functioning funeral home and — in the best small-town tradition — furniture store.

While Dr. Sawtell undoubtedly viewed his job as carrying heavy responsibilities, they were of a very different nature than those confronting his latter-day cousin. The early years of the century were stressful for the practice of medicine in Kan-

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sas because of developmental changes which must have seemed to the principals to approach the revolutionary. Appropriately, he touched on these in his presidential address in May 1908. The State Board of Examination and Registration, on which he served, was still only seven years old and, of necessity, balancing its state-endowed power and its professional obligations. The primary issue which had prompted the Kansas Medical Society to struggle for half a century for such a board, and which was foremost in the minds of its members, was the elimination of quacks, an all-but-hopeless struggle (and a continuing one, since it is still going on).

**“Though the line may be
devious, collateral is a term
as dear to [a genealogist]
as to a banker.”**

The Council on Medical Education of the American Medical Association was moving to tighten the rules on medical education by forcing the elimination of proprietary schools. This gave impetus to the development and improvement of state medical schools and helped to press the state to settle on a formalized curriculum of basic sciences at the University of Kansas in Lawrence and the concomitant establishment of a school for the clinical years which, after several years of rivalry among various towns, was located in Kansas City (thanks to Dr. Simeon Bell). It was in this climate that Dr. Sawtell came to head the first department devoted to rhinology and laryngology. (It is of some significance, perhaps, and a tribute to the impact of Dr. Sawtell and his colleagues that, for many years, the specialists in the eye, ear, nose and throat area would hold their own separate meetings at the times of the annual KMS meetings.)

The medical cares of that day are reflected in Dr. Sawtell's Presidential Address, delivered in May 1908, in Iola (the one and only time the society met there since, as he mentioned as diplomatically as possible, it was not too easy to get to, nor were the facilities ideal for handling the group).

If the current proponents of preventive meas-

ures in health matters think they are onto something, they are advised that this was one of the prime concerns of Dr. Sawtell and his colleagues, though on a somewhat different plane. Both public health officials and physicians were adapting the principles developed as the germ theory of disease gained acceptance. In his address, Dr. Sawtell congratulated the State Board of Health for its efforts in obtaining sanitary laws and education of the public (aided, of course, by private practitioners). “Let the public understand,” he said, “that one of the main purposes of our organization is for public advantage, and that preventive medicine is the climax of professional unselfishness, and not an empty pretense.”

The business of disease prevention took many forms. He cited the need for a vital statistics registration law, though he recalled that a committee had previously been appointed and acknowledged that all his listeners were sufficiently aware of the matter, so that no additional comment was needed. He urged the members to give their support to the development of state institutions for the care of tuberculous patients, but again urged an effort toward public education including the creation of a tuberculosis exhibit as being “productive of more extensive results than the institutional method.” Knowledge imparted to the uninfected, he contended, was “vastly better than making the effort to cure after infection.”

Nutritional matters were of as much concern in principle for Dr. Sawtell and his fellow practitioners as they would become a few generations later (though perhaps not in the conflicting detail apparent today, when any study is certain to be refuted by other studies before the public has digested the original). A pure food and drug law was only a few years old and had been prompted by the adulteration of lard with cottonseed oil based, in his words, “upon the protection of the American hog.” This was followed by the more recent Oleomargarine Bill, and Dr. Sawtell's complaint was that these measures were based on commercial considerations rather than elements on which “the comfort, the health and lives of the community so largely depend.”

Dr. Sawtell had kind words to say for *The Journal of the Kansas Medical Society*, understandable considering his several years as a co-editor, but he reflected on an ever-present problem. “The *Journal* has not, as yet, become self-sustaining but through new arrangements recently made by the Council for its management and publication, it is confidently hoped that this result can be achieved

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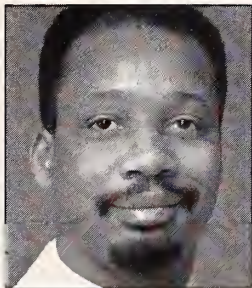
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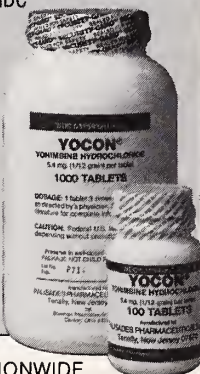
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The problems accompanying medical changes bore little resemblance to those confronting his young cousin. A primary concern was the issue of fee-splitting which, as surgery increased its hold on profession and public, was acknowledged to be one of the prominent and evil temptations confronting practitioners. This was an issue of strong national concern, but in true professional patriotism, Dr. Sawtell noted that "I do not believe this evil exists in this state to the extent that it does in other localities, nor that it is as prevalent as commonly reported. Personally I can speak for the integrity and good name of the profession, as I have never been approached with an offer that was mercenary in any sense."

The difficulties — and rewards — of present-day medical practice seem far removed from those faced by Dr. Sawtell and his colleagues. It is worth noting, for example, that the issue of malpractice did not warrant mention in Dr. Sawtell's address, nor did national insurance plans or third parties. But those practitioners did contend with a burgeoning governmental bureaucracy, the problems of convincing a self-indulgent public that health measures were productive of demonstrable economic value as well as straightforward comfort and the difficulties of providing the best possible medical care despite the incursions of opportunists and critics.

Still, they enjoyed the same compensations derived from their service as would be in style more than 80 years later. After all of the meetings and conferences and current stresses of the job, perhaps Dr. Meek will be able to say, as Dr. Sawtell did, "to uphold the honor and dignity of our profession is a well defined duty, both as individuals and as a Society. A proper respect for our own profession, emanating from the members of our profession, will better insure a full measure of return from the public" — and with the satisfaction and pride in his profession Dr. Sawtell seems to have felt. Family trait, perhaps.

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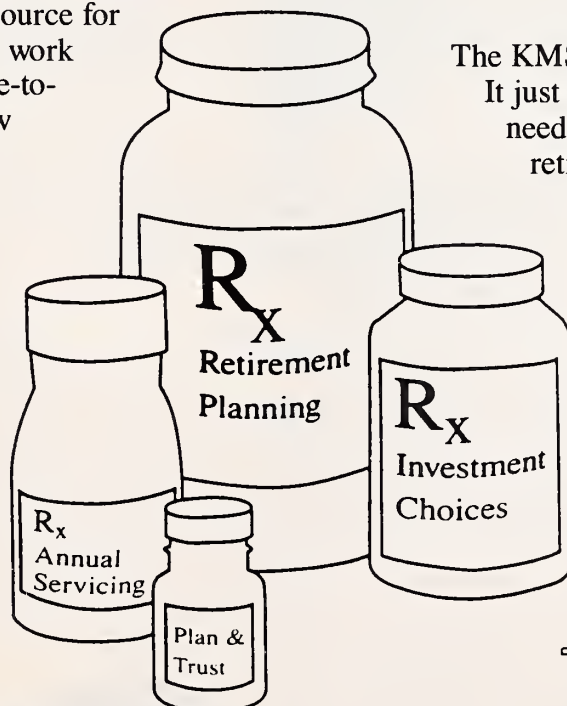
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Adult Respiratory Distress Syndrome in Early-Stage Pneumonia

JOSE M. BEJAR, M.D.,* *Topeka*

Adult respiratory distress syndrome (ARDS) is a noncardiac pulmonary edema characterized mainly by an increase in capillary permeability with interstitial and alveolar edema of the lungs.¹ Mortality may be greater than 75% in patients requiring an inspired oxygen concentration (FiO_2) greater than 50%.² ARDS can result from acute local lung injury, as in patients who aspirate gastric fluid, or from indirect lung injury, as in non-thoracic trauma or sepsis.³ This is a case report of ARDS in a patient with early-stage methicillin-resistant *Staphylococcus aureus* (MRSA) pneumonia.

Case Presentation

A 63-year-old gentleman with a history of chronic schizophrenia and seizure disorder was admitted in a comatose state due to a large, intracerebral hemorrhage in the right hemisphere, complicated by uncal herniation caused by ruptured arteriovenous malformation (AVM) three days before admission. With adequate general support measures (tracheostomy, feeding gastrostomy tube placement, etc.), the patient gradually improved, and the coma resolved. By the eighth to ninth week of his hospital course, he was capable of following some simple commands and making short, appropriate comments. He had presented with an unusually high production of bronchial secretions and recurrent bronchitis due to different bacteria, including *Streptococcus pneumoniae* and *Serratia marcescens*, which resolved with antibiotic therapy.

By the tenth week of hospitalization, he developed, rather suddenly, labored breathing, tachypnea (more than 30 breaths per minute), mild fever (100°F, rectal temperature), tachycardia (100 beats per minute) and a markedly decreased amount of bronchial secretions, which became bloody. His mental state remained unchanged. There were no signs of heart failure,

such as jugular vein distention (JVD), hepatomegaly or ankle pitting edema. CBC showed 11.9 K/cmm white blood cells (WBC, 4.8–10.8). Repeated arterial blood gases showed increasing hypoxemia: ABG: PH 7.39 (7.35–7.45); pCO_2 46.8 mm Hg (35–45); pO_2 46.0 mm Hg (80–90); HCO_3 28.7 mEq (22–26); O_2Hb 79.1% (85–98). Serial chest x-ray films revealed a diffuse and rapidly progressive infiltration involving 5 lung lobes, which was interstitial at first, followed by the emergence of bilateral alveolar infiltration (see figure 1); pulmonary veins were not dilated and heart size was grossly within normal limits.

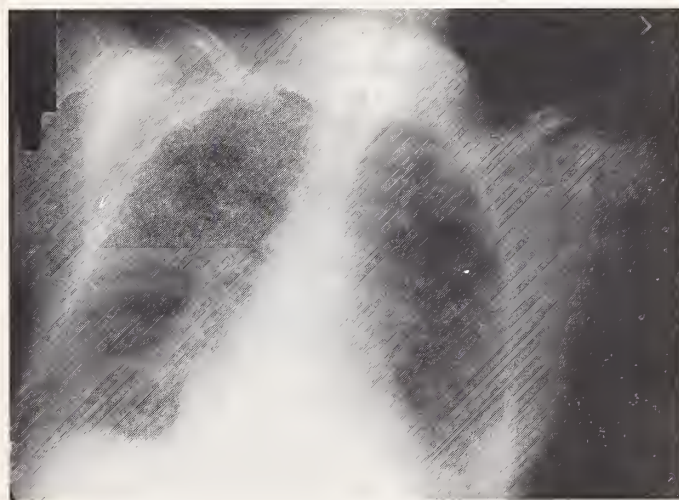


Figure 1. Portable chest x-ray shows diffuse interstitial and alveolar infiltration.

A Gram's stain, culture and sensitivity of deep endotracheal aspiration sample obtained through the tracheostomy tube, showed *Staphylococcus aureus* resistant to methicillin (MRSA), nafcillin, oxacillin (penicillinase-resistant penicillins), but sensitive to vancomycin, which was administered intravenously in increasing doses, up to 900 mg every 8 hours, monitoring its peak and trough levels. It was felt that the patient had developed MRSA pneumonia, which in its early stage became complicated by ARDS. With vancomycin treatment, the fever and tachycardia resolved and WBC returned to normal range (10.2 K/cmm). The patient improved transiently with continuous

*Colmery-O'Neil VA Medical Center

Address correspondence and reprint requests to Dr. Bejar at Colmery-O'Neil VA Medical Center, 2200 Gage Boulevard, Topeka, Kansas 66622.

positive airway pressure (C-PAP). His closest kin did not give their consent to place him on a respirator or insert a Swan-Ganz catheter to measure pulmonary artery wedge pressure, and requested that he not be resuscitated. The patient died due to respiratory failure.

Discussion

ARDS is a form of pulmonary edema without elevation of pulmonary capillary hydrostatic pressure. It may be due to increased permeability of the alveolocapillary membrane via direct injury (aspiration, massive pulmonary infection), or indirectly (sepsis) through activation of neutrophils adhering to endothelial surfaces of the pulmonary capillaries. This produces injury of the alveolocapillary membrane through the release of mediators of inflammation (leukotrienes, thromboxanes, prostaglandins). The result is leakage of liquid, macromolecules and cellular components into the interstitial space and alveoli, increasing vascular permeability to proteins. This leaves the hydrostatic gradient unopposed, so that mild elevation in capillary pressure leads to greatly increased interstitial and alveolar edema.¹⁻⁶

A debilitated elderly man with tracheostomy

presented with tachypnea associated with progressive hypoxemia. The chest roentgenogram displayed diffuse infiltration which, with bloody sputum and presence of MRSA indicated by Gram's stain and culture, was consistent with early-stage pneumonia complicated by ARDS. There was no evidence of heart failure by physical examination or x-ray studies. The respiratory infection resolved with antibiotic therapy.

ARDS occurs following catastrophic insults or risk factors such as sepsis, shock, aspiration, trauma, burns or diffuse pulmonary infection.^{4,5} This case is unusual due to the development of ARDS following early-stage pneumonia, which is not a catastrophic event. It seems likely that MRSA injured the alveolocapillary membrane and triggered ARDS without the development of diffuse pulmonary infection.

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Surveys indicate that one of the principal reasons that professionals join their respective associations is for representation in governmental policymaking. Yet those association members are oftentimes uninformed about the policymaking process and frequently ask what their lobbyist actually does. While associations or businesses recognize that there are certain benefits derived from representation, the principals remain curious as to the technique involved in passage of legislation.

The term "lobbyist," while practical, is somewhat unfortunate, as it fails to express the appropriate purpose of the function: the provision to legislative bodies of specialized or technical information of value in the making of laws. Since government attempts to combine the interests of all the entities it governs, reliance upon information relating to the function of those different entities is not only desirable but essential. It follows, then, that individuals or groups possessing such specialized information should be a significant factor in the legislative process, and the often-maligned process of "lobbying" is based finally on the integrity of those involved, from the sponsoring group (and its representatives) through the lawmakers. Indeed, the laborious process of accomplishing lawmaking is an effort to determine that the information beginning with the lobbyist and resulting in statutory regulations will be as representative of the public interest as possible.

Contrary to the opinions of some, lobbyists are dedicated professionals, most with advanced educational degrees. They participate in the political process because of a fascination with government and policymaking, rather than from any motivation to peddle influence or capitalize on the system. The fact is, in Kansas at least, votes cannot be bought for any price.

The principal role of the lobbyist, then, is to provide communication to the policymakers and the interest represented. It is extremely important that the lobbyist's qualification to transmit the policy goals of the association or corporation be effectively communicated to legislators and other elected officials. This process may be accomplished during meetings in statehouse offices or

"Association members frequently ask what their lobbyist actually does."

by informal contacts and may be instigated by either party. Such meetings are not unlike contacts made by marketing representatives in the normal course of doing business. After all, a lobbyist has something to sell, albeit ideas and principles rather than goods or services. It is also important that the lobbyist present formal testimony at public hearings. This requires both written and verbal skills in order to be effective. In communicating information to legislators, it is important to interpret the policy goals of the organization in terms of the welfare of the legislators' constituents. The probability of success is enhanced greatly when the individual legislator can be convinced that those goals are in the best interest of the average voter.

The communication process is actually a year-round occupation. Many people believe that legislators and lobbyists take lengthy vacations between legislative sessions, during which time they engage in other occupations or their favorite hobbies. To the contrary, many controversial issues are studied during the period of time between the legislative sessions.

In Kansas, early June is the usual time when the Legislative Coordinating Council assigns various study topics to special interim committees. In early summer, two-day meetings generally commence. At this time, several topics of interest to any organization may be assigned to a number of different interim committees for consideration during the same year. For example, during the 1990 interim there were seven different topics assigned to the Public Health and Welfare Committee. In addition, the Insurance Committee engaged in a comprehensive study of health insurance, the Local Government Committee studied financing of emergency medical services, among several other topics, and there was a Task Force

on Social and Rehabilitation Services, which studied the state medical assistance program, as well as other aspects of the department. In addition to these special interim committees, the Health Care Stabilization Fund Oversight Committee concluded its study of whether or not the fund should be phased out. The Joint Committee on Health Care Decisions for the 1990s commenced its study of health care issues by engaging in hearings and discussions of bioethics and access issues. In the meantime, the Governor's Commission on Health Care conducted public hearings, held discussions and concluded a series of recommendations for the Governor.

Although there may be a few days of respite between interim committee meetings, it is not uncommon for two committees to meet on the same day. This means that the lobbyists, and sometimes legislators, must try to attend both meetings at once — not an easy task. This is why lobbyists and legislators seem to appear and disappear strangely during different phases of the meetings, causing some members of the general public in the audience to develop misconceptions about activities of legislators and lobbyists.

Interim committees must conclude their discussions and recommendations in November or, at the latest, early December. This allows the staffs time to compile reports for publication for the Legislature when it convenes in January.

When the Legislature actually begins the new session year, the policymaking process accelerates. The level of activity can seem overwhelming at times and may require that both legislators and lobbyists work long hours for most of the period from January through April. The Legislature does try to impose some structure on the lawmaking process by establishing deadlines for certain activities. There is a deadline for introduction of bills by the individual legislators and a later deadline for the introduction of bills by committees. There is also a deadline for consideration of bills by the so-called house of origin and, of course, another deadline for bills considered in the second house. This means that the lobbyist must be well organized and plan ahead in order to accomplish goals of the organization represented.

Early in the process, the lobbyist must approach the appropriate committee chairman and request an opportunity to appear for introduction of a bill. This does not, however, guarantee that the bill will ever be considered by the committee. The lobbyist must follow up by convincing the chairman that the particular measure is worthy of

a hearing. The hearing may last one hour, or can involve several days of one-hour hearings. Sometimes a hearing may be concluded in a matter of minutes, depending on the level of controversy surrounding that particular piece of legislation.

In any event, it is imperative that the lobbyist shepherd the bill through the committee process and insure that it is reflected on the calendar of the House or Senate well before the impending deadline. If the deadline is not met, the bill is dead for the balance of the legislative session. There are exceptions to the rules applying to certain committees. For example, if a bill is introduced by an appropriation committee, it is not subject to deadlines. This, however, is an extraordinary method of circumventing the normal process. It is far more advisable to respect the legislative deadlines by requesting introduction of bills and hearings at appropriate times.

Throughout the legislative session, it is important for the lobbyist to maintain constant vigilance. This means that the lobbyist must read all bills as they are introduced to determine whether there may be relevance to the policy concerns of the association or business represented. It is also necessary to analyze amendments to bills to determine whether or not the bill has been substantially changed in a manner that would be of concern. Vigilance requires presence at all committee hearings when relevant bills are discussed. There is always a possibility that a legislator may wish to direct a question to a lobbyist.

It is also necessary to be present during "the committee of the whole," that is, the entire House of Representatives or the Senate. At this time, lobbyists actually live up to the title by waiting in the lobby while legislators debate the bills on the floors of the respective chambers. It is not uncommon for a legislator to walk out of the chamber to discuss a particular measure with the lobbyist. At such times, it is essential to be helpful to legislators by providing answers to their questions or information that may be pertinent to the debate. *It is imperative that the lobbyist always be honest with legislators and admit if he or she does not know the answer to the question.* Any lobbyist who attempts to improvise or provides erroneous information sacrifices credibility. Without credibility, a lobbyist can never expect to be successful in achieving the policy goals of the represented organization.

The normal course of enactment of a law will involve study by an interim committee, hearings and formal action by the first committee, debate

in the committee of the whole, final action in the house of origin, hearings and formal action in the second committee, debate in the second committee of the whole, final action in the second house and eventually signature (or veto) by the Governor. Because a bill can be amended at just about any stage in that process, there may also be a requirement for what is called a "conference committee." A conference committee consists of both representatives and senators who discuss the differences between the House and Senate versions of the bill and attempt to compromise on a final version of the legislation. This can prolong the process and require an additional vote in both the House and Senate. The conference committee report, if accepted, constitutes final passage of the bill.

This entire process can easily span a 12-month period when the bill is the product of an interim study. There are, moreover, some bills that actually take many years to become law. An excellent example is the limit on noneconomic damages that was initiated by the Kansas Medical Society.

As the liability situation worsened in the late 70s and early 80s, the KMS advocated limiting

unquantifiable damages in medical malpractice cases. The Legislature studied the subject in 1985, and the interim committee recommended limitations on noneconomic damages (in medical malpractice cases only). This recommendation was adopted by the 1986 Legislature.

In July 1987, the Kansas Supreme Court issued a decision regarding a different law, but indicated in that decision that medical malpractice should not be governed any differently compared to other personal injury cases. This was based on the equal protection provision in the Bill of Rights. The 1988 Legislature responded by reenacting a limit on noneconomic damages that made the limit applicable in all personal injury cases. One month later, the Kansas Supreme Court declared the 1986 limit unconstitutional, but this decision was based on a violation of the right to trial by jury, rather than the equal protection argument.

As a result of the two unfavorable Supreme Court decisions, the Kansas Medical Society embarked on a campaign to amend the Kansas Constitution in a manner that would clarify the Legislature's authority to limit the amount of damages awarded in a personal injury suit. This particular measure was being considered by the 1989 Leg-



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islature when, in March, the Kansas Supreme Court announced a decision in a different case which upheld a limit on noneconomic damages. The Court did not issue a written elaboration of that decision, but simply announced their vote. Almost a year later a written decision was issued which clarified the basis for the Supreme Court's decision and the apparent reversal in attitude. This law, first enacted in 1986, is just now beginning to affect medical malpractice claims.

The Kansas Medical Society's nearly-5-year ordeal to effect a reasonable limit on noneconomic damages in medical malpractice cases is an example of how perseverance and patience can sometimes be necessary in order to achieve success in policymaking. Any expectation of quick and easy deals at the State House is certainly unrealistic. Lobbying should be deliberate and must be done in an ethical and professional manner in order to be effective and successful. The professional lobbyist respects our system of governmental policymaking and plays by the rules — though this contrasts with the popular public image often promoted by the news media.

PRESIDENT'S MESSAGE

(Continued from page 6.)

major reasons for which the campus in Wichita was created: the clinical education of medical students. We must be vigilant in providing the most effective education possible for our students, delivered by a competent and compassionate faculty. As Wichita continues to develop its biomedical research programs, UKSM-W must expand its role as a research institution in order to attract the best and ablest of clinical faculty. Linkages with the Kansas City campus will further expand the emerging research programs in Wichita. And most importantly, as the Wichita campus develops and extends its multiple outreach educational programs, it should do so in partnership with the Kansas physicians and their representative organization, the Kansas Medical Society. Together, these institutions can lead Kansas medicine to a new level of excellence, thus justifying the beginning of a new voyage.

Joseph E. Lueck, M.D.

THE WAY IT WAS

(Being a report of medical history and conditions culled from past issues of the *Transactions of the Kansas Medical Society* and its offspring, *The Journal of the Kansas Medical Society* and *Kansas Medicine*.)

Before the days of flavored, sugar-free Metamucil, before the time of chocolate Ex-Lax and long before oat bran was fashionable, there was Uncle Sam Breakfast Food. The following column appeared under the heading "Rx" in the October 1914 issue (volume 14, page 394) of The Journal of the Kansas Medical Society.

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Not that the KMS membership of the day was preoccupied solely with the laxative properties of food. As the following account, from the March 1914 issue, shows, some members were quite the gourmets:

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Electrophysiologic Testing

DONALD L. VINE, M.D., *Department of Medicine, UKSM-Wichita*

Guidelines for the performance of electrophysiologic testing have been jointly published by the American Heart Association and the American College of Cardiology.¹

Classification

The guidelines are divided into classes to facilitate their usefulness. Class 1 indications signify general agreement among experts that patients with the condition under consideration should undergo electrophysiologic testing. Class 1 indications should be familiar to primary care physicians. Class 2 indications are those for which some experts felt that electrophysiologic study was indicated and some did not. Class 3 indications represent those that were generally agreed to be inappropriate reasons for performing electrophysiologic evaluation.

Table 1 lists Class 1 (indicated) and Class 3 (not indicated) guidelines for common clinical problems.

Examples

According to these guidelines, electrophysiologic

testing should be performed in patients with unexplained syncope and structural heart disease, cardiac arrest not associated with an acute Q-wave myocardial infarction and palpitations with a documented rapid pulse rate but no ECG diagnosis.

Frequent premature ventricular contractions and, presumably, short salvos of non-sustained, asymptomatic ventricular tachycardia are not presently considered indications for electrophysiologic testing.

Other recommendations and an extensive bibliography are included in the published report.

REFERENCE

1. Guidelines for clinical intracardiac electrophysiologic studies. A report of the American College of Cardiology/American Heart Association Task Force on Assessment of Diagnostic and Therapeutic Cardiovascular Procedures (subcommittee to assess clinical intracardiac electrophysiologic studies) *Circulation* 1989;80:1925-39.

TABLE 1.
ELECTROPHYSIOLOGIC TESTING

Condition	Indicated (Class 1)	Not indicated (Class 3)
Unexplained palpitations	<ul style="list-style-type: none"> • Inappropriately rapid pulse rate documented by medical personnel (e.g. > 150 BPM) 	<ul style="list-style-type: none"> • Palpitations due to extracardiac disease such as hyperthyroidism
Premature ventricular complexes	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • Asymptomatic patients with PVCs
Wide-QRS tachycardia	<ul style="list-style-type: none"> • Sustained and/or symptomatic wide-QRS tachycardia when diagnosis is unclear and is needed for treatment 	<ul style="list-style-type: none"> • Patients with wide-QRS tachycardia which can be diagnosed by conventional ECG criteria
Unexplained syncope	<ul style="list-style-type: none"> • Unexplained syncope and known or suspected structural heart disease 	<ul style="list-style-type: none"> • Cause of syncope is known
Survivors of cardiac arrest	<ul style="list-style-type: none"> • Cardiac arrest without evidence of an acute Q-wave infarction • Cardiac arrest occurring later than 48 hours after acute myocardial infarction 	<ul style="list-style-type: none"> • Cardiac arrest occurring within first 48 hours of acute myocardial infarction • Cardiac arrest resulting from acute reversible ischemia or other clearly identifiable cause (e.g. aortic stenosis, congenital long Q-T syndrome)

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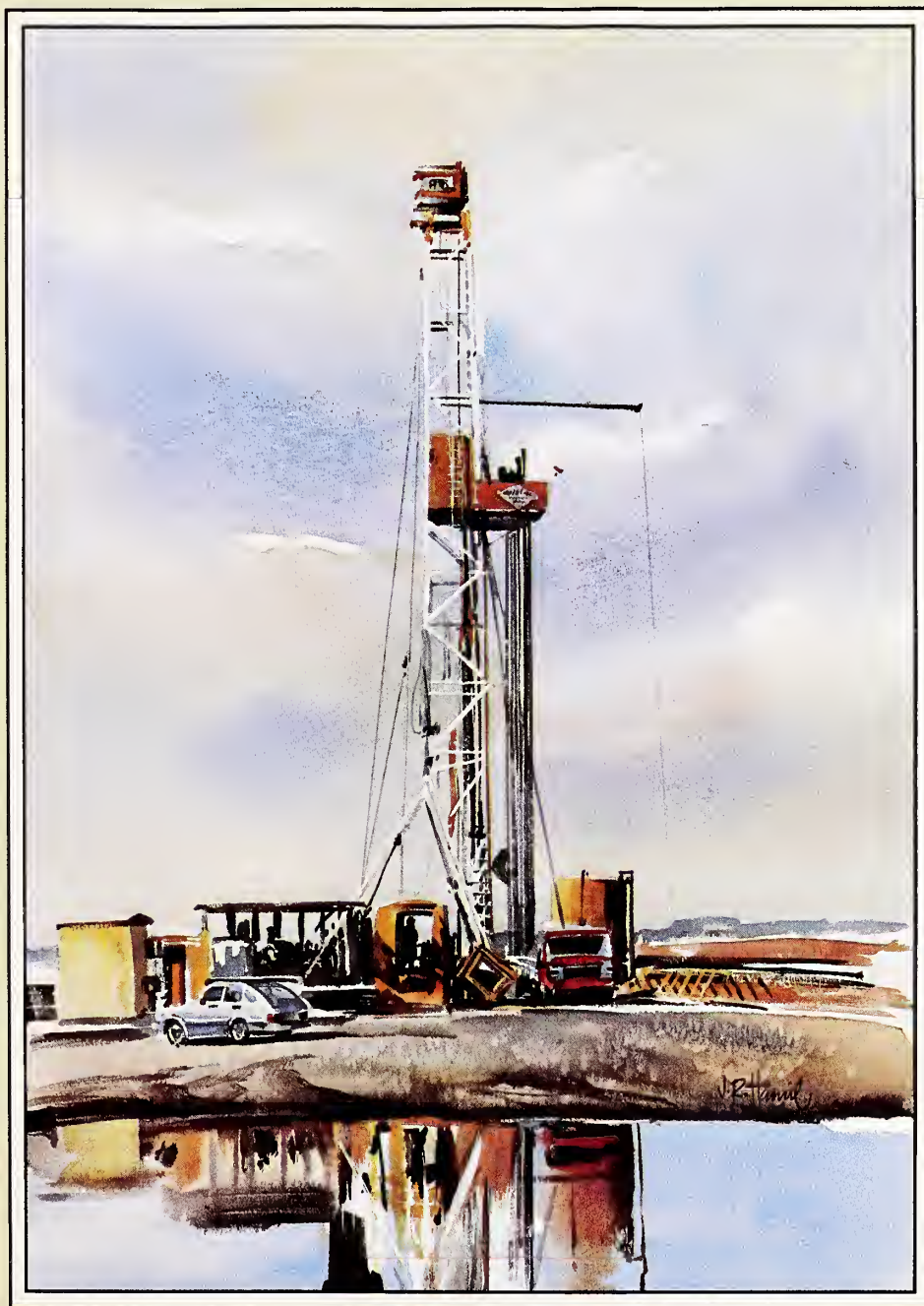
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ABOUT OUR LOGO

In January 1935, a new logo appeared on the cover of KANSAS MEDICINE for the first time. This device represents two stethoscopes: the original monaural type as used by Laënnec, and the modern binaural variety. The logo was designed expressly for KANSAS MEDICINE by renowned graphic designer Bradbury Thompson, a native of Topeka and friend of two former editors of the journal, Dr. W.M. Mills and Dr. Lucien Pyle. As another former editor, Dr. Orville R. Clark, wrote in January 1955, the logo "has become as much a part of the journal as any of the features on the inside and is something which is ours alone."

However one feels about the role of oil in international politics and economics, it has been and still is a significant factor (and actor) in Kansas life. Styles have changed in oil wells, and the current forms look almost sissified compared to the old wooden derricks with their huge arms pumping the black gold that has been the cause of alternating booms and busts in state and local economies. Whether or not oil is worth a war has long been debated (and fought out) and will probably continue to be until an improved replacement is found for one or the other. Jim Hamil's watercolor of "McCoy #1," near Garden City, is a representative of the new type of well, and Sharon Hamil's account of Kansas' contributions to the world of energy are counterpoint to it, as their *Return to Kansas* records:

"Petroleum, helium and natural gas production result in economic opportunities extending throughout Kansas. Chanute's oil field equipment and supply plants and natural gas wells and oil refineries near El Dorado join countless other businesses capitalizing on these natural resources. The Hugoton Gas Field, one of the world's largest natural gas deposits, and the Mid-Continent Oil Field, the country's largest, are famous nationwide.

"Indian legends tell of councils held around burning springs and of cures provided by the oily waters. Pioneers used the heavy oil for medicine and to grease their wagon wheels. The first successful oil well west of the Mississippi was Norman No. 1, drilled in 1892 near Neodesha. Oil derricks and pumpers are common sights in Kansas today."

And the smell of the wells and refineries, abhorred by many, can still evoke a sense of nostalgia in those who recall it from their earliest days.

The Seventh Age

The matter of aging has received much attention in recent years and promises to demand more before society is fully comfortable with it. Sociologically, it is a moving target, since the diversity of aging's effects confounds all but the most general solutions. Medical attention has been both voluntary and forced, and finally dignified by the specialty of gerontology. However, the process is not always a matter of destructive pathology and, as there is a significant increase in the aged group (however defined), there is an increase in such persons retaining reasonably sound health and productivity. This has led to a variety of pursuits — social, political and academic — designed to satisfy the interests of those who are capable. And there have been endless commentaries about what to do with the old folks.



The fact is that the process is not any one thing — neither an accomplished state of pathology nor a Golden Age of Personal Discovery. It is, rather, a gradual process accomplished by the incursion of increments of degeneration and malfunction that complicate previously simple efforts. This summing up sounds grim, but the point is that the process is, for the subject, often self-deniable for extended periods, resulting in friction between the individual and those observing the changes from the outside.

The measurement of a person's senility requires placement of the individual in his or her setting. Absent some specific disease state, the social and domestic circumstances are probably as much a factor in the manifestations of the aging state as wear and tear on the organism. The term "aged," in itself, sets a definitional limit which is necessarily broad, since the variety of minds and bodies so classified is extensive. But there is often an undeniable fact: the approaching (though unknown) limit of life develops in ways unrealized during earlier days of concern with other problems.

This is not a morbid reminder that death is in the offing; it is a simple awareness of that finite, but unknown, limit (and the fact that we owe more to our inherent autonomic nervous systems than to any health advisories or uplift programs). Positive thinking is fine, but an increasing focus

on health matters — if not of one's self, then those of a spouse or relative or friend — is forced on most individuals. One becomes gradually (though by no means unknowingly) adjusted to a life schedule incorporating the demands of aging, and they become accepted, sometimes philosophically, sometimes resentfully.

Those working with the aging know (or should know) that, whatever the individual circumstances, it is a depersonalization process. In the words of an elderly lady, moving into a retirement complex apartment, "Now I'm just a name on the door."

Aging is a reduction process, externally as well as internally. The successive limits of capability (and, it can be said, need) usually require a reduction in the size of quarters, with elimination of valued mementoes. With each stage of increasing disability, there is an accompanying detachment from those connections with earlier times — and movement into a shrunken world. A form of geriatric happiness, perhaps, would be an equivalent loss of physical and intellectual capabilities, so the process of leaving the past is less traumatic.

That variety of lifestyles adopted by the aging is often the product of the variety of family circumstances obtaining. There are those in which a strong familial sense of responsibility (not to mention economics) dictates that the aged person will remain within that group. There are those who may not have such available — or know that the "live-in" arrangement is untenable. Blessed is the family where this is known and amicably accepted on both sides.

In either case, however, this may simply defer the matter since (unless mortality resolves it earlier), there is certain to come a time when closer attention is required and the prospect of some intermediary care must be faced. Increasingly, the problem becomes one of the interposition of the thoughts and feelings of others for those of the individual. There can be no stronger argument for the maintenance of informed and considerate interpersonal relationships between the generations than this, a firm basis of the desired and desirable. As gerontologists are aware, the physician's role should encompass much more than organic pathology. **D.E.G.**

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Stabilizing the Fund

Health care issues continue to demand attention among a number of groups in Kansas. The 1991 Kansas Economic Conference sponsored by the *Wichita Eagle* has just taken place, and one of the three major topics for discussion was health care costs. Access to health care received a great deal of discussion, and the recent proposal for reform of U.S. health care developed by the Kansas Employer Coalition on Health was presented as one initial step to correct the inequities that exist in our current system. In addition, the conference attendees received the Executive Summary of the recently completed report of the Governor's Commission on Health Care. Both of these documents represent input from a wide variety of health care providers, insurance and business leaders and consumers. A number of the proposals are bold and will require study by the Kansas Medical Society's Committee on Access to Health Care.



These merging initiatives within the state of Kansas are matched by similar programs that are occurring throughout the United States. This was discussed at some length in the 1991 State Health Legislation Meeting conducted by the American Medical Association. During this conference, a discussion was held concerning the state of Maine's plan to adopt practice parameters as a part of the regulation of the practice of medicine. As an inducement for physicians in the specialties of obstetrics and gynecology, emergency medicine and anesthesiology to participate, a physician named as a defendant in a malpractice action occurring between 1992 and 1996 may introduce evidence of compliance with the parameters as an affirmative defense to a negligence claim.

We continue to hear disturbing reports of physicians becoming disenchanted with the practice of medicine, particularly in the area of primary care. The January 1 issue of the *Annals of Internal Medicine* is full of reports of dissatisfaction among general internists, residents and students. Major factors in the dissatisfaction of practicing internists were malpractice liability and lack of control of malpractice insurance premiums.

In this changing environment, the Kansas

Medical Society has been asked to review the status of the Health Care Stabilization Fund. Initially established by the Kansas Legislature to provide excess limits above conventional malpractice coverage, the fund has grown in recent years to represent a multimillion-dollar reservoir for payment of large claims. Tort reform, so successfully orchestrated by the Kansas Medical Society, holds the promise of continued premium relief to the Kansas physician. With improved conditions, there is a move afoot to consider termination of the Health Care Stabilization Fund.

Many Kansas legislators are inclined to move out of the professional liability insurance business, and therefore favor either termination of the fund or transfer of the fund to a non-State agency. Better than half of Kansas' physicians favor elimination or restructuring of the Health Care Stabilization Fund, with the goal of diminishing the high premium surcharge that has only recently shown some downward turn. Other physicians, particularly those in the high-risk specialties, such as obstetrics, have urged caution in the discussion relating to termination of the fund. The Kansas Medical Society is listening carefully to all arguments and has taken the position that the fund should be made actuarially sound by 1994 so that it could be terminated at that time if, and only if, conditions warrant a return to the private market. It also seems prudent to examine the options of transferring operation of the fund into the private insurance sector and out of state government control. However, we must do everything possible to make certain that practicing physicians can receive affordable malpractice insurance that covers all physician services, including obstetrical care. Because of the liability risks, primary care physicians are retreating from the non-metropolitan practice locations where exposure is so great, thereby forcing obstetrical care into a diminishing circle of health care providers.

It seems to me, therefore, that the Kansas Medical Society must continue to work to develop plans which reduce the costs of litigation and improve the attractiveness of primary care practice in Kansas. The two reports mentioned above address the negative impact of excessive malpractice

(Continued on page 54.)

AIM HIGH



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The Kansas Coroner

WAYNE T. STRATTON, J.D.,* *Topeka*

In Kansas, the coroner occupies a somewhat unique position, being an officer possessed of considerable discretion, but also required to perform many ministerial functions. The task the coroner performs is vital to society, and is frequently accomplished with a minimum of publicity and acclaim. Many physicians will have cases which potentially could involve the coroner.



By Kansas statute, a coroner must be notified when any person dies, or when a human body is found dead and the death is suspected to have been the result of violence, or caused by unlawful means, suicide or casualty. The coroner must also be contacted if the death was sudden and the decedent had been in apparent good health, or if the decedent was not regularly attended by a licensed physician. Finally, when a person's death occurs in any suspicious or unusual manner, or a determination of the cause of death is held merely to be in the public interest, the physician in attendance, or any other person required by law, should notify the coroner's office.

Upon receipt of such notice, the coroner must take charge of the body, make inquiries regarding the cause of death, and release the findings in a written report. This report must be filed with the clerk of the district court of the county in which the death occurred. If, in the opinion of the coroner, it is advisable that an autopsy be made, it will be performed by a pathologist designated by the coroner. In the case of an unexpected death of a live-born child under the age of one year, the coroner is required by statute to inform the parents that an autopsy is mandatory and will be

Is a coroner immune from lawsuits?

performed. The law does not permit the coroner any discretion in these cases.

In addition to autopsies, it is the coroner's responsibility to hold an inquest when a person's death appears to have been caused by unlawful means, yet the circumstances surrounding the death are unknown. The coroner is required to summon six residents of the county to inquire into the cause of death.

Kansas law recognizes an action for emotional distress for interfering with a dead body. Several such actions have been brought, alleging the performance of a wrongful autopsy. To succeed, the plaintiff must prove that the acts were intentional or malicious, as opposed to negligent, interference with the next-of-kin's right to the body.

Generally, the discretionary acts of the coroner are protected by the governmental immunity attached to the office. Failure to order an autopsy or call an inquest is not actionable. The failure to perform ministerial acts may lead to liability only in limited circumstances. It is said that the coroner is qualifiedly immune in such circumstances; that is, only when not acting in good faith, or when acting completely outside the scope of the statutory duties.

*KMS Legal Counsel.

Comments appearing herein are not intended as a substitute for legal analysis or advice. Answers to legal questions depend largely upon the particular facts of a case. The reader is urged to consult an attorney for answers to specific legal questions.

These comments do not necessarily represent the views of KANSAS MEDICINE, or the Kansas Medical Society. For further information, contact Mr. Stratton, 515 S. Kansas, Topeka, KS 66603, 1-800-332-0248.

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To be eligible for consideration, physicians must have "practiced in Kansas continually for at least a five-year period" and must *not* be "connected or affiliated with medical groups who number more than five (5) practicing physicians."

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How to Apply

Applications should be received no later than April 15, 1991 in order to be considered for the 1991 grant year. An application form may be obtained by writing to:

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Am Fam Phys 1987;36:133-140

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- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon.

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- Stevens-Johnson syndrome, toxic epidermal necrolysis,

and anaphylaxis have been reported rarely. Anaphylaxis may be more common in patients with a history of penicillin allergy.

- Gastrointestinal (mostly diarrhea): 2.5%
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypotonia, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1% and, rarely, thrombocytopenia and reversible interstitial nephritis.
- Abnormalities in laboratory results of uncertain etiology:**
- Slight elevations in hepatic enzymes.
- Transient lymphocytosis, leukopenia, and, rarely, hemolytic anemia and reversible neutropenia.
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THE WAY IT WAS

(Being a report of medical history and conditions culled from past issues of the *Transactions of the Kansas Medical Society* and its offspring, *The Journal of the Kansas Medical Society* and *Kansas Medicine*.)

[The physician] may, by becoming socially popular, by acting promptly and curing his patients, meet with partial success; and when there is but little competition, he may succeed with hard work in making a competence, but if he expects to amass something to support him in retirement, when it becomes necessary for him to yield to younger men, he will have to lend his energy and talent to rescuing his profession from its present degraded position in the estimation of the public. The ignorant say that all doctors experiment, and guess at the disease as well as the remedy, and their only aim is to keep the patient sick so they may run up a bill; that they are guilty of as many tricks as those of any other trade. . . . In the estimation of the whole community our profession has fallen to the level of a trade so low it is entered upon by the student only as a last resort, and all are struggling to leave it as early as possible. (*Transactions* 1873, p. 234)

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Full details and registration forms
have been mailed.

KANSAS NOTIFIABLE DISEASE REGULATIONS

Changes as of December 24, 1990

CINDY WOOD, M.D., M.P.H.,* Topeka

In all U.S. states and territories, certain diseases must be reported to public health authorities. Each state and territory determines which diseases will be reportable within its jurisdiction. Disease reporting is mandated to assist public health agencies in protecting the health of the populations they serve. Over time, all such lists of reportable diseases, known as notifiable diseases, become outmoded and require revision. This occurs because of the eradication of diseases, increased knowledge of the epidemiology and long-term consequences of diseases, and the emergence or identification of new diseases.

KAR 28-1-2

In Kansas, all persons licensed by the Board of Healing Arts are required to report suspected or confirmed notifiable diseases. Reporting to the county board of health was formerly mandated. The local public health unit, in turn, reported notifiable diseases to the Department of Health and Environment (KDHE). A change in Kansas Administrative Regulation (KAR) 28-1-2 now allows direct reporting to KDHE. However, reporting to the local health department is still preferred and encouraged, except in the case of acquired immunodeficiency syndrome (AIDS) and human immunodeficiency virus (HIV) infection, which are to be reported directly to KDHE. The wording of KAR 28-1-2 has been simplified. Multiple diseases caused by related microorganisms have been grouped, as have diseases caused by different pathogens, but with similar clinical manifestations. An example of the former is the grouping of trachoma, psittacosis and chlamydia cervicitis and urethritis as "*Chlamydia sp.* infections." An example of the latter is the grouping of several types of meningitis as simply "meningitis." It should now be easier for the physician to deter-

*Kansas State Epidemiologist.

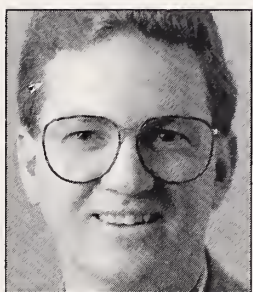
Address correspondence to Dr. Wood at KDHE, Bureau of Disease Control, 109 SW 9th Street, Suite 605, Topeka, Kansas 66612-1271.

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KANSAS REPORT OF NOTIFIABLE DISEASE CARD				VERSION 1-91	
Disease or Suspected Disease _____					
Patient's Name _____			Sex M F		Race _____
Last Name	First Name	MI			
Address _____		Birthdate ____-____-____	Age _____		
City _____		Zip Code _____	County _____		
Date of Onset ____-____-____		Hospitalized Y N			
Hospital _____			City _____		
Pre-school, School, or Occupation _____					
Physician _____			Physician Telephone ____-____-____		
Remarks _____					
Reported by _____			Telephone ____-____-____		
Send Supply of Report Cards to: _____					

Figure 1. Draft of Kansas Report of Notifiable Disease Card, front.

mine whether the disease he or she suspects or has diagnosed is reportable.

Several diseases have been dropped from the list of notifiable diseases. These are amebiasis, ancylostomiasis, infectious keratoconjunctivitis, lymphocytic choriomeningitis, pediculosis, scabies, smallpox, and tinea capitis and corporis. These changes reflect diseases which are either eradicated (smallpox), exceedingly rare or, most commonly, not significantly impacted at the state level.

Three diseases have been added to the list. They are Kawasaki disease, Lyme disease, and tularemia. The first two are diseases that have been recognized relatively recently as matters of public health importance. The last is a potentially life-threatening disease for which the initiation of formal surveillance is indicated.

Revised Kansas Report of Notifiable Disease Cards should be available this month. A draft version of the new card is shown in figures 1 and 2. As is usual, the list of notifiable diseases will be printed on the back of the cards (figure 2). Until revised cards are available, physicians should continue using the report cards they have on hand. Cards may be ordered by calling the Bureau of Disease Control at 913-296-5591. When an immediate threat to the public health is identified, physicians are urged to notify their county health officer immediately by telephone. Such threats would include suspected or confirmed cases of measles, meningococcal or *Haemophilus influenzae* meningitis, pertussis and rubella.

An in-depth discussion of the changes in no-

tifiable disease regulations was distributed to each local health department in December, and will be printed in the spring 1991 bulletin of the KDHE Bureau of Disease Control, to be mailed in mid-to late February. The bulletin, *EPISTAT*, is available free of charge to any health care worker. It may be ordered by telephoning the Bureau of Disease Control at 913-296-5586.

KAR 28-1-22

Kansas Administrative Regulation 28-1-22 has been changed to require the reporting of cases of infection with human immunodeficiency virus (HIV) that do not meet the criteria for a diagnosis of acquired immunodeficiency syndrome (AIDS) to KDHE. Reports are to include demographic and medical information, but are not to include names. HIV infection should be reported on special HIV report cards and mailed directly to the AIDS Section, Bureau of Disease Control, KDHE, 109 SW 9th Street, Suite 605, Topeka, Kansas 66612-1271. Supplies of HIV report cards and more information about reporting HIV infection are available from the above address, or by telephoning 913-296-6173.

AIDS remains a notifiable disease under Kansas Statute Annotated (KSA) 65-6002. Reporting forms and assistance are available from the number above.

Confidentiality

As always, KDHE holds reports of notifiable diseases in strict confidence. At times physicians will be contacted by KDHE staff to obtain informa-



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Brief, concise articles are preferred; an ideal manuscript will not exceed five double-spaced pages. All material will be edited by the editorial staff to assure clarity, good grammar and appropriate language, and to conform to KANSAS MEDICINE style and format. When feasible, material may be condensed.

The author will be asked to review the **galley proof** prior to publication. Although editing and proofreading will be done with care, the author is responsible for accuracy of material published. The galley proof is for correction of ERRORS; rewriting of material *must* be done prior to submission. Authors are urged to check manuscripts and galley proof carefully for errors that could result in inaccurate information.

Drugs should be referred to by generic names; trade names may follow in parentheses if useful. All **units of measure** must be given in the metric system.

KANSAS MEDICINE will print a maximum of **ten references**. All references should be keyed with superscripts in the text in the order cited. If more than ten sources are cited, readers will be referred to the author for the complete list.

Illustrative material must be identified by its referral number in the text and be accompanied by a short legend. **Photos** should be black-and-white glossy prints. **Tables** should be self-explanatory and should supplement, not duplicate, the text.

KANSAS MEDICINE will assume the cost of black-and-white figures and tables for two units. A unit is defined as ¼ page. The author(s) will be billed for additional units at cost.

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REPORTABLE DISEASES

As Required by Kansas Regulations

AIDS/HIV (DO NOT USE THIS CARD. Call 913-296-6173).

Anthrax
Botulism
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Campylobacter Infections
Chancroid
Chickenpox
Chlamydia sp. Infections
Cholera
Diphtheria
Encephalitis, Infectious (Indicate Infectious agent)
Epidemic diarrhea of the newborn
Food poisoning (Indicate causative agent)
Giardiasis
Granuloma inguinale
Hepatitis, viral (Indicate causative agent)
Herpes simplex, genital
Histoplasmosis
Kawasaki disease
Legionellosis
Lyme disease
Lymphogranuloma venereum
Malaria
Meningitis (Indicate causative agent)
Mumps
Neisseria gonorrhoea Infections
Pertussis
Plague
Poliomyelitis
Q fever
Rabies
Rickettsialpox
Rocky Mountain spotted fever
Rubella, including congenital rubella syndrome
Rubeola (measles)
Salmonellosis, including typhoid fever
Shigellosis
Staphylococcal disease, hospital-acquired
Streptococcal disease, group A beta-hemolytic
Syphilis
Taeniasis and cysticercosis
Tetanus
Trichinosis
Tuberculosis
Tularemia
Typhus
Urethritis, other than gonococcal or chlamydial
Vaginitis, non-specific
Yellow fever

Send disease report cards at least weekly to your local health department. Additional information may be requested.

Other diseases are reportable by hospital administrators and clinical laboratories.

For more information contact your local health department, or call the Kansas Department of Health and Environment at 913-296-5586.

Figure 2. Draft of Kansas Report of Notifiable Disease Card, back.

tion necessary for the proper investigation of a case of infectious disease. Should the physician have any reason to doubt the identity of the caller, he or she should end the conversation, then call the Bureau of Disease Control at 913-296-5586 to confirm the caller's identity.

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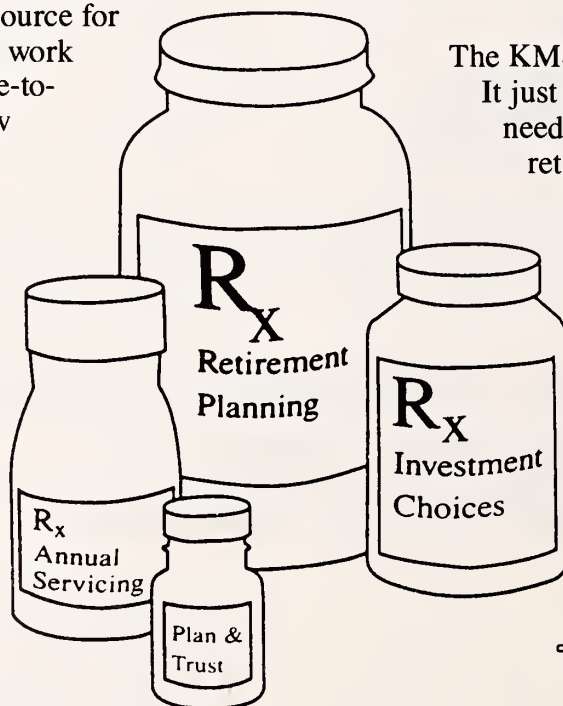
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Intraoperative Radiation Therapy in the Treatment of Recurrent Carcinoma of the Head and Neck

STEVEN D. BRAUN, M.D.,* LINDA S. GEMER, M.D.,* RAE A. MCINTEE, M.D.,† REGINALD BAUGH, M.D.,† JAMES H. THOMAS, M.D.,‡ AND RICHARD G. EVANS, M.D., PH.D.,* *Kansas City*

Patients with advanced or recurrent head and neck cancer have an extremely poor prognosis. Their clinical course is often characterized by progressive, disfiguring disease with ulceration of the tumor and the associated complications of infection and bleeding, leading to difficult nursing problems. Many patients, such as the one presented in this paper, have very few "standard therapy options" remaining, due to failure of previous multimodality treatments. Intraoperative Radiation Therapy (IORT) for advanced or recurrent head and neck tumors may be an alternative as an aggressive, yet reasonable, procedure aimed at improving local control and the quality of life.

Case Report

L.F. is a 61-year-old female with a history of T3N0M0 moderately differentiated squamous-cell carcinoma of the right tonsil, originally diagnosed at another hospital in November 1983. The patient underwent preoperative radiotherapy to 5000 cGy, delivered to the primary lesion and draining lymph nodes. This was followed by a right radical neck dissection, resection of the hemimandible, composite resection of the palate, tonsillar fossa and right base of tongue and reconstruction with a myocutaneous flap. L.F. did well until December 1987. At that time she was noted to have a biopsy-proven lesion in the right pyriform sinus and a solitary right-upper-neck mass, the latter being considered unresectable due to tumor adherence to the right carotid artery. A chemotherapeutic regimen was undertaken using 5-fluorouracil and cis-platinum. Both masses

demonstrated a complete response to chemotherapy. In June 1989 a recurrence was again noted in the same region of the right upper neck. This was determined to be the patient's only site of disease. L.F. was then started on the same regimen of 5-fluorouracil and cis-platinum. A repeat CT scan showed little, if any, improvement in the size of the right-neck mass after three courses of chemotherapy. Due to near-tolerance doses of previous radiation to the area, as well as the fact that the tumor seemed to be adherent to the carotid artery, it was decided that meaningful doses of conventional external-beam radiotherapy could not be delivered without risking severe complication, including radiation myelitis, carotid rupture, osteoradionecrosis and acute and chronic dermatitis. The patient was then placed on weekly methotrexate and referred to the Department of Radiation Oncology at the University of Kansas Medical Center.

Subsequent Clinical Course. Chest x-ray, direct laryngoscopy with biopsy of the previously involved pyriform sinus, cervical sonogram, CT scan of the head and neck and carotid arteriogram were performed. The chest x-ray showed no evidence of metastatic disease. Biopsies from the pyriform sinus were negative for involvement by malignant disease. The cervical sonogram revealed a $2.8 \times 2.8 \times 4$ cm mass at the bifurcation of the right carotid artery. Branches of the external carotid artery were seen within the mass. It was felt that there was extension of the tumor with encasement also of the internal carotid artery. The CT scan confirmed the above findings and demonstrated, in addition, the increase in size of the mass on comparison with the outside study performed one month previously. No other site of disease was evident on CT scan. The carotid arteriogram demonstrated 75% stenosis of the left carotid and 90% stenosis of the right carotid artery.

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L.F. underwent a left carotid endarterectomy on November 5, 1989, in order to ensure cerebral perfusion during the anticipated manipulation of the right carotid at the time of tumor debulking and intraoperative radiotherapy (IORT) which was to follow. L.F. returned on December 1, 1989, for right carotid artery bypass grafting, tumor debulking and IORT. Drs. Rae McIntee and Reginald Baugh of the ENT Department at Kansas University Medical Center proceeded with exposure of the right upper neck mass. The tumor was noted to be adherent to the carotid artery at the level of the bifurcation, therefore requiring en bloc resection with carotid artery bypass graft placement, which was performed by Dr. James Thomas. A gross total resection of the right upper neck mass was accomplished. Drs. Steven Braun and Linda Gerner then proceeded with the delivery of a single intraoperative dose of radiation, using the 20 MeV linear accelerator in the Radiation Oncology Department's dedicated IORT/operating suite. A dose of 2000 cGy was delivered to the 90% isodose line using 9 MeV electrons. The electron beam was directed using a 5.1 cm circular, 15° beveled IORT cone. Prior to the docking of the IORT cone to the tumor bed, care was taken to gently displace the carotid artery bypass graft from the field of radiation. Also excluded from the field of radiation was the reconstructed mandible and all previously irradiated skin. The final pathology report revealed poorly differentiated squamous cell carcinoma with the surgical resection margins being histologically free of disease.

Discussion

This case represents a joint effort by the members of four departments at Kansas University Medical Center to provide an aggressive, but reasonable, procedure aimed at improving local control in a patient with regional recurrence. IORT is presented as a treatment modality being explored around the world in many centers. Its current facility is predominantly in the treatment of locally advanced refractory cancers in which quality of life, if not survival, may be impacted by the improvement in local control. IORT involves the delivery of a single large dose of radiation at the time of maximum exposure of either an unresectable neoplasm or the bed of a grossly, totally resected tumor during the surgical procedure. Direct visualization of the area at greatest risk for recurrence allows the radiation oncologist to tailor treatment precisely, using one of various ener-



Figure 1. Checking placement of the IORT cone within the tumor bed to ensure coverage of areas at greatest risk for recurrence, while excluding as many normal structures as possible from the field of radiation.

gies of electron beams (relating to the depth of penetration of the beam) and cone sizes (dictating the length and width of the field of radiation). A major advantage of IORT is the exclusion of most normal structures from the path of the beam of radiation in an attempt to improve the therapeutic ratio by reducing the incidence of complications due to radiation toxicity in adjacent normal structures. These advantages described with IORT afforded this patient a reasonable therapeutic option which was otherwise lacking using "standard treatment modalities." IORT could be given in this case, while excluding the previously irradiated skin, mandible and newly placed carotid graft from the field of radiation.

Modern IORT is said to have begun under Abe and coworkers using a megavoltage machine in 1964. Use of IORT as an accepted form of treatment in advanced or recurrent neoplasms first spread through Japan. The Japanese experience demonstrated an improvement in survival in a comparative study of 194 patients with gastric carcinoma treated by gastrectomy and IORT.¹ Matsumoto et al. reported a survival advantage using IORT in patients with bladder carcinoma.² Other Japanese authors have demonstrated the use of IORT in the treatment of a variety of other malignant diseases, including carcinoma of the biliary tract, prostate and pancreas, as well as in the treatment of patients with soft-tissue sarcomas.^{3,4,5,6}

Henschken Goldson of Howard University introduced IORT to the United States in 1975. Initial use of IORT included the treatment of para-aortic lymph nodes in patients with carcinoma of the cervix.⁷

A pilot study out of Massachusetts General Hospital (MGH) reported on 12 patients with localized, but unresectable, carcinoma of the pancreas treated with preoperative external beam radiotherapy, followed by IORT, followed by postoperative external beam radiotherapy.⁸ Chemotherapy was administered in 6 of the 12 patients. The median survival in patients treated with IORT was found to be 15 months. This was compared to a median survival of 10.5 months seen in a group of historical controls treated at the MGH between 1961 and 1971 for resectable pancreatic carcinoma.⁹ Encouraging results from the United States have been achieved in patients with both soft tissue sarcomas and colorectal carcinoma.

A state-of-the-art IORT facility has been built and is currently being used at the University of Kansas Medical Center, Department of Radiation Oncology. One of the radiation therapy rooms within the radiation oncology department has been renovated and functions as a totally operational surgical suite complete with a Varian 20 MeV linear accelerator, which can produce high-energy electrons as well as x-rays. As of December 1989, 46 patients had been treated with IORT at Kansas University Medical Center. This paper describes the first case of a patient with advanced head and neck carcinoma treated at the University of Kansas Medical Center with IORT.

In summary, patients with advanced or recurrent head and neck cancer have an extremely poor prognosis. Their clinical course is often characterized by progressive, disfiguring disease, with ulceration of the tumor and the associated complications of infection and bleeding, leading to difficult nursing problems. Many patients, such as the one presented in this paper, have very few "standard therapy options" remaining, due to failure of previous multi-modality treatments. IORT for advanced or recurring head and neck tumors may prove to offer an alternative for these patients.

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VOX DOX

Medical Writer Seeks Humorous Stories

To the Editor:

After 23 years of reporting the serious side of medicine for Westinghouse Broadcasting in Los Angeles, I am currently writing a book on the lighter side. The book, tentatively titled *Keeping Your Doctor in Stitches*, deals with true incidents that take place in a physician's practice, at his or her office or in the hospital.

This book is designed to show the funny side of medicine. It will deal with those situations you have all experienced, in which the words or actions of patients and colleagues have left you limp with laughter. My book will cover all medical specialties. Patients will be kept anonymous, and doctors and nurses may also remain nameless if they so desire. For more information on this project, read the April 20, 1990 issue of *American Medical News*.

I would like to include your stories in the collection. If you wish to submit stories, please include your name, address, medical specialty and hospital affiliation. Send your stories to me at 12327 Erwin Street, North Hollywood, California 91606, or telephone me at 818-980-0458.

Don Herbert
North Hollywood, California

Indian Health Service Offers Satisfying Work

HERMAN W. HIESTERMAN, M.D.,* *Quinter*

Last winter sped by very quickly and enjoyably for my wife and me. We spent this doldrum time of year doing part-time work in the Indian Health Service. We worked one month at the Sioux Sanatorium, Rapid City, South Dakota; two weeks at Sisseton, South Dakota; and then two weeks at Rocky Boy Reservation Health Clinic in Northern Montana. Before we knew it, spring was here and with it all the usual home busywork of yard, flowers and garden. We plan to pass the winter this way again from time to time.

My wife accompanied me to all three locations and enjoyed the change of pace, soaking up the local color, shopping, and especially the camaraderie of other wives of doctors who were also doing part-time work. To me it was a fascinating experience, both culturally and professionally. Our Native Americans have special problems and special needs. I found them to be friendly and appreciative, and occasionally "different." I was impressed by the number of Indians who are well educated, productive and progressive (some doctors, many nurses, pharmacists, social workers and numerous others in administrative and clerical positions).

I must confess I was also saddened by other facts of Indian life that I witnessed first hand: the many social problems, such as alcohol and drugs, and the seeming purposelessness of life for some. Medically, from my brief experience, my appraisal is that health care for our Native Americans is very good — yes, even better than in some areas in the private sector. Through the efforts of the Indian Health Service, substantial progress has been made in the last 30 years. The mortality rate for tuberculosis has declined 96%, and the infant mortality rate has decreased by 83%.

There are approximately 1.5 million Native

*Address correspondence to Dr. Hiesterman at Quinter Clinic Building, 116 East 4th, Quinter, Kansas 67752.

Send your story for "The Days of Our Age" to Susan Ward, Production Editor, KANSAS MEDICINE, 1300 Topeka Avenue, Topeka, Kansas 66612.



A bilingual sign beside the open door invites patients to enter the Chippewa-Cree Health Center on the Rocky Boy Reservation near Box Elder, Montana.

Americans receiving health care from the IHS. Currently, it is an agency of the U.S. Public Health Service, a division of the Department of Health and Human Services. Native American health care facilities are scattered all over the continental United States, including Alaska.

It was by the coincidence of a brief rest period and the "at-hand" issue of *Family Practice News* that I became aware of the Indian Health Service



The larger and more imposing Sioux Sanatorium, in Rapid City, South Dakota, was built in 1936.

"To me it was a fascinating experience, both culturally and professionally."

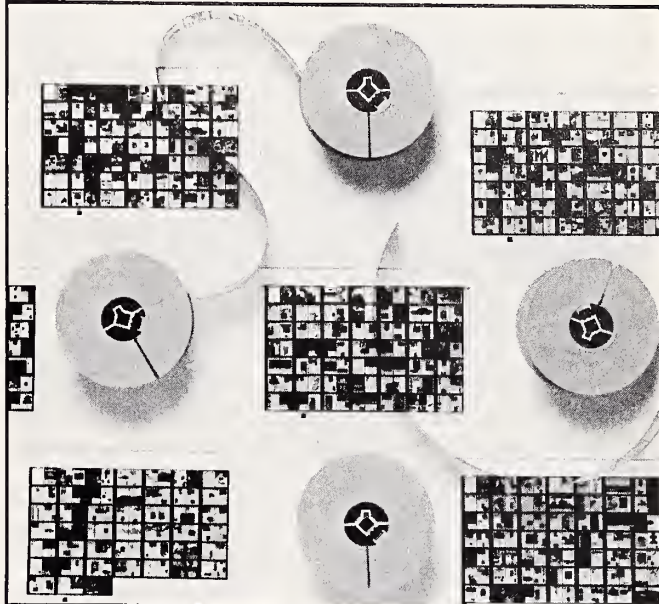
and its need for additional full- and part-time physicians. As I recall, there was a special appeal for help from recently retired doctors. After finishing the article, my curiosity gained momentum and I contacted John Naughton, of the AMA's Project U.S.A. That is how it all started.

I recommend work at the Indian Health Service for the recently retired (and others) because 1) it's needed; 2) it offers personal satisfaction; 3) it's an adventure; 4) it's just as good or better than CMEs for learning; 5) it supplements retirement income; 6) and more. One caveat: This is not for everyone. But, as they say in some circles, "Try it; you might like it."

For more information, contact Mr. John Naughton, Project U.S.A., c/o American Medical Association, 515 N. State St., Chicago, Illinois 60610.

This article continues our ongoing series describing the various lifestyles enjoyed by our retired physicians. Let your fellow KMS members know what life is like now that you have retired. Do you enjoy your new lifestyle? What do you do for recreation? Do you have a new career? Is your health good? Did you plan adequately for your retirement? How? What would you do differently if you were planning now to retire? Any of these subjects, plus many more, are fair game for this column. Send us your thoughts today!

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FAMILY PRACTICE: Hospital-sponsored clinic opportunity. Dynamic, growth-oriented hospital in beautiful North Central Wisconsin is seeking Family Physicians to join a growing practice in a new facility. The administrative burdens of medical practice will be minimized in this hospital-managed clinic. The hospital has committed to an income and benefit package which is significantly higher than similar opportunities. Package includes base income, incentive bonus, malpractice, disability, signing bonus and student loan reduction/forgiveness program. All relocation costs will be borne by the hospital. Please contact Kari Wangness, Associate, The Chancellor Group, Inc., France Place, Suite 920, 3601 Minnesota Drive, Bloomington, Minnesota 55435; 612-835-5123.

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Too Little Cholesterol Reduction May Be Hazardous

DONALD L. VINE, M.D.,* *Wichita*

The American Heart Association has editorially responded to criticisms of cholesterol reduction published in the lay press with the assertion that cholesterol reduction does reduce mortality.¹

Two recent articles suggest that unbridled enthusiasm for a national policy of dietary change may overlook some important considerations.

Non-disease Mortality

One finding of the Lipid Research Clinics Coronary Primary Prevention Trial that received less emphasis than others was the *increase* in mortality which was not associated with disease, such as suicides and fatal accidents. Strangely, a similar finding was noted for the Helsinki Heart Study.

Muldoon et al. performed meta-analysis on the six available randomized primary prevention trials which produced significant cholesterol reduction in the treatment group and evaluated both total and cause-specific mortality.¹

The odds ratio, which is the risk for treated groups divided by the risk for control subjects, is less than one if there is benefit and greater than one if there is harm. In the case of total mortality, there was no significant benefit. The reduction in coronary heart disease mortality was marginally significant ($p = 0.06$), and the mortality increases associated with cancer ($p = 0.01$) and non-disease causes ($p = 0.004$) were highly significant (figure 1).

All-trial Review

A similar review by Ingar Holme included all available randomized trials of cholesterol reduction for either primary or secondary prevention of mortality or coronary heart disease death³ (figure 2). There were 19 studies, with a total of 103,598 subjects. The difference in total mortality for all treated, versus control subjects, was only

70 subjects. The difference for coronary heart disease deaths was 432.

When the risk of death from any cause was correlated to the magnitude of cholesterol reduction achieved, there appeared to be an excess mortality associated with cholesterol reductions of less than 10% and a reduced mortality when cholesterol reduction exceeded 10% (figure 3).

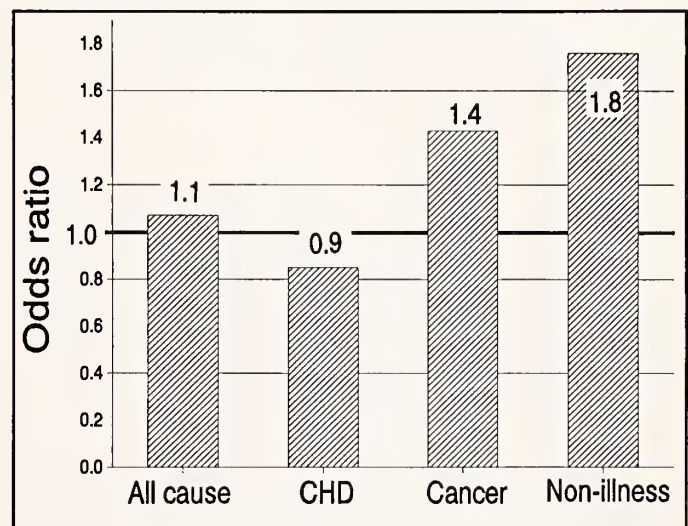


Figure 1. Odds ratios for mortality by cause of death. The odds ratio is the likelihood of death for the treatment group, divided by that for the control group. An odds ratio of one indicates no difference; of greater than one, an increased mortality associated with treatment. (From Muldoon, et al.)

Comments

One implication of Holme's analysis is that half-hearted attempts at cholesterol reduction, say by diet alone, may be more hazardous than none at all. If this were true, there would have to be a reevaluation of the recommendations we make to patients with elevated serum cholesterol. In Holme's review, the greatest benefit was associated with drug, versus diet, trials and secondary, versus primary, prevention studies.

The apparent increase in non-coronary heart disease mortality associated with cholesterol reduction may turn out to be a statistical anomaly,

*Associate Professor, Department of Medicine, University of Kansas School of Medicine-Wichita

Address correspondence to Dr. Vine, Department of Medicine, UKSM-W, 1010 N. Kansas, Wichita, KS 67214.

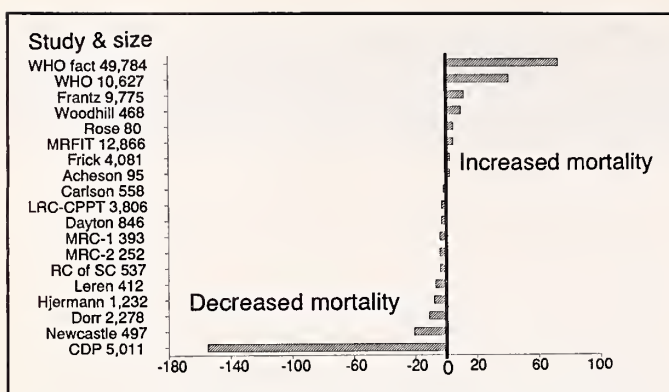


Figure 2. The excess number of deaths associated with treatment for each trial reviewed by Holme.

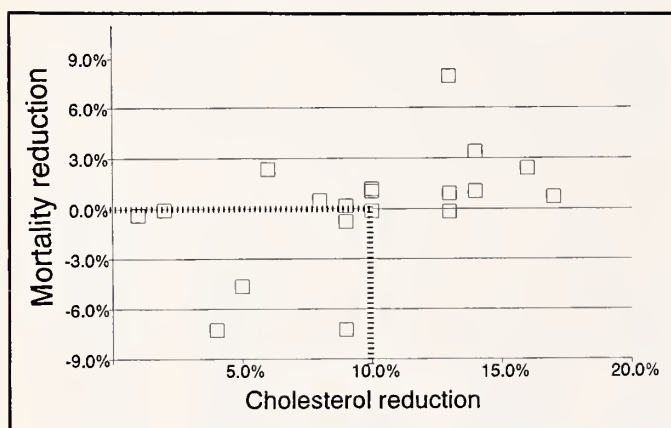


Figure 3. Relationship between the reduction in cholesterol and the reduction (or increase) in mortality for each of the studies reviewed by Holme.

but the possibility remains that there are risks as well as benefits associated with cholesterol reduction, even when accomplished by diet alone.

Finally, it might be argued that after the randomization of more than 100,000 subjects to trials of diet and/or drugs for the lowering of cholesterol, the continued inability to demonstrate a clear-cut reduction in overall mortality means that the reduction is either non-existent or trivial in magnitude.

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PRESIDENT'S MESSAGE

(Continued from page 34.)

litigation. The KECH Health Care Reform proposal states, "Because of the pressures for medical inflation caused by malpractice litigation, the committee feels that government must take strong measures to reform the tort system in a more cost-conscious direction." The Governor's Commission on Health Care has two specific recommendations towards tort reform to primary care and controlling the cost of health care. Recommendation No. 37 states in part, "Develop long-term solutions to the medical malpractice problem by continuing the study of the Kansas Tort System as a method for resolving medical malpractice claims." Recommendation No. 28 suggests that "statutes be revised to allow public hospitals to pay physician medical liability insurance premiums to increase community ability to attract medical providers."

The malpractice crisis in the state of Kansas has not yet been resolved, but positive steps toward controlling the problem have been taken. The Health Care Stabilization Fund may have created an unwanted financial lure to trial lawyers; nevertheless, it has accomplished the goal of providing protection to our physicians from excessive malpractice claims, particularly in higher-risk areas such as obstetrics. We must do everything we can to assure current and future physicians that malpractice insurance will be both available and affordable. I am confident that the KMS leadership will do everything they can to achieve this. After all, without a solid foundation of primary care providers in our state, there can be no rational system of care for our citizens.

Joseph E. French, M.D.

Notes & Quotes

NEWS FOR AND ABOUT KMS MEMBERS

JANUARY 1991

AMA Releases Statement on HIV-Positive Physicians

Following a report from the Centers for Disease Control on three dental patients who apparently contracted HIV from their dentist, on January 17 the AMA Board released the following statement:

"Physicians who are HIV-positive have an ethical obligation not to engage in any professional activity which has an identifiable risk of transmission of the infection to the patient. (See Report of the AMA Council on Ethical and Judicial Affairs, Ethical Issues Involved in the Growing AIDS Crisis, December 1987, reprinted in JAMA, vol. 259, pp. 1360-61.) Many patients have been treated by HIV-infected physicians, and there have been no documented cases of transmission from physician to patient.

"However, the recent cases of possible dentist-to-patient transmission have caused some uncertainty about the risk of transmission from physicians to patients under certain circumstances. In cases of uncertainty about risks to patient health, the medical profession, as a matter of medical ethics, should err on the side of protecting patients. The health of patients must always be the paramount concern of physicians. Consequently, until the uncertainty about transmission is resolved, the American Medical Association believes that HIV-infected physicians should not perform invasive procedures which pose an identifiable risk of transmission, or should disclose their seropositive status prior to performing the procedure and proceed only if there is informed consent. As a corollary, physicians who are at risk of acquiring HIV infection, and who perform such invasive procedures, should periodically determine their HIV status.

"Some invasive procedures pose no identifiable risk of transmission, e.g., a bronchoscopy. Others, such as surgical procedures, cannot, with the same conclusiveness, be said at this time to pose no identifiable risk of transmission, given the current analysis of the Centers for Disease Control regarding three patients of a Florida dentist.

"The American Medical Association further believes that physicians who are HIV-positive and who must restrict their normal professional activities have a right to continue their career in medicine in a capacity that poses no identifiable risk to their patients. The American Medical Association pledges its support and protection of these physicians and believes the profession and the public have an obligation to ensure that they continue to be productive as long as they practice medicine safely and responsibly."

Conference on Physician Health Will Be Held in Toronto

The 1991 International Conference on Physician Health, sponsored by the American Medical Association, the Canadian Medical Association and the Federation of Province Licensing Authorities, is scheduled for June 6-8, 1991 in Toronto,

Ontario. The conference, entitled Caring for the Caregiver, will provide a forum for practitioners and researchers on the area of physician health to present their findings, as well as innovative treatment and educational programs.

Specific areas of physician health to be addressed at the conference include substance abuse, mental illness, physical disability, aging, AIDS and stress. Information regarding health issues impacting medical students, residents and practicing physicians will also be addressed. For more information, contact Val Braun at KMS, 800-332-0156 or 913-235-2383.

Information on Certified Nurse Aides Is Now Available by Telephone

KDHE has compiled a listing of certified nurse aides to help insure quality care of the state's nursing home residents. The Kansas Nurse Aide Registry was established as part of the federal Omnibus Budget Reconciliation Act, which sought to improve the quality of nursing home care. It forbids nursing homes from hiring certified nurse aides who have been convicted of abuse, neglect or mistreatment. Under the act, nursing homes and long-term care units in hospitals are required to call the registry before using a person as a certified nurse aide. More than 50,000 individuals are recorded on the state registry.

The Kansas Nurse Aide Registry began taking phone calls from facilities and the public in January. It is open from 8 a.m. to noon and from 1 to 3 p.m. weekdays except state holidays. The phone number is 296-6877.

KUMC Offers Nutrition Information by Phone

Another source of information over the telephone is Food Talk, a new service provided by KUMC, which offers both consumers and health care professionals up-to-date information on nutrition. The service is supported by an extensive library on nutrition at the medical center's department of dietetics and nutrition, and by the collection of books and journals at the Archie R. Dykes Library.

Call Food Talk Monday through Friday from 9 a.m. to 5 p.m. at 588-5350 in the metropolitan Kansas City area, or at 800-633-0445 from other areas in Kansas, Missouri, Colorado, Oklahoma, Nebraska, South Dakota and western Iowa.

Grants Available for Renal Research

The Renal Division of Baxter Healthcare Corporation invites submission of proposals for the fifth round of its Extramural Grant Program, which will fund research in two areas: Beta₂-Microglobulin Amyloidosis, or an open category. The open category is intended to allow scientists working in all areas of renal research an opportunity to apply for grants. The deadline for submission of requests is April 12, 1991. Full details may be obtained from Lee Henderson, M.D., Executive Director, Extramural Grant Program, 708-270-5201.

Congratulations

...To Ronald L. Martin, M.D., who was named president-elect of the Kansas Psychiatric Society for 1990-92.

...To Joe J. Lin, M.D., who is president-elect of the International Association of Chinese Pathologists.

...And to Charles F. Shield, III, M.D., who was appointed to the Advisory Committee to the Surgeon General's Workshop on Organ Donation.

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Urokinase Infusion in Total Occlusion of Peripheral Vascular Disease



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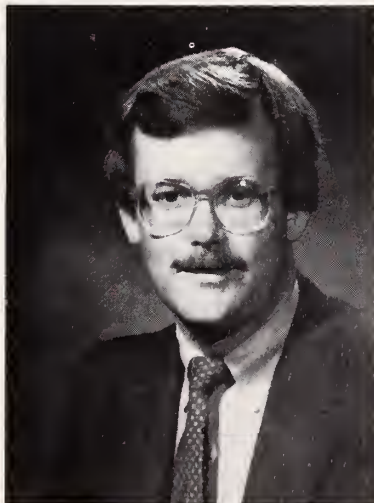
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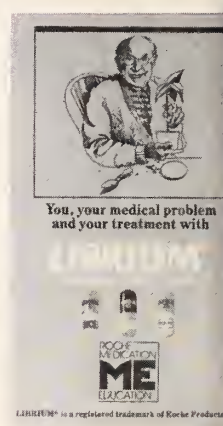
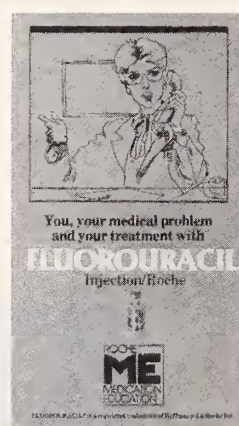
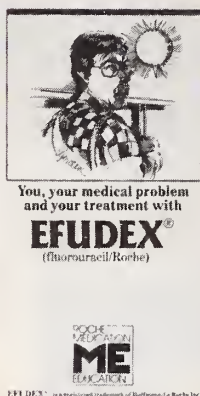
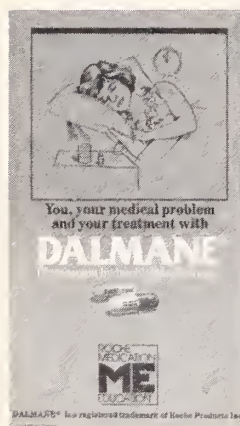
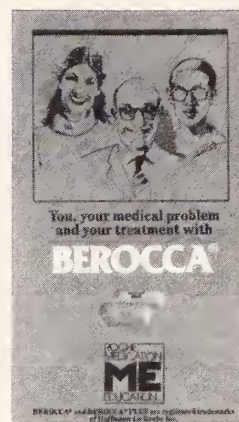


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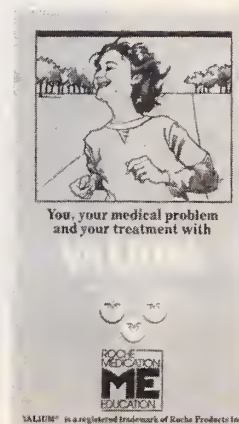
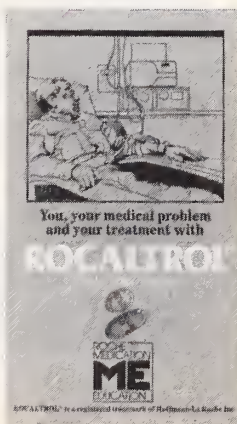
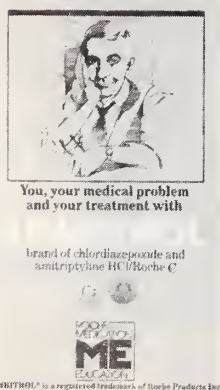


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**ABOUT OUR LOGO**

In January 1935, a new logo appeared on the cover of KANSAS MEDICINE for the first time. This device represents two stethoscopes: the original monaural type as used by Laënnec, and the modern binaural variety. The logo was designed expressly for KANSAS MEDICINE by renowned graphic designer Bradbury Thompson, a native of Topeka and friend of two former editors of the journal, Dr. W.M. Mills and Dr. Lucien Pyle. As another former editor, Dr. Orville R. Clark, wrote in January 1955, the logo "has become as much a part of the journal as any of the features on the inside and is something which is ours alone."

Kansas, in common with its neighbors comprising what geographers call the Plains States, is not well understood by those from other parts of the country. Occasionally, visitors admire the openness and vastness (usually the sky), but in greater number, these uninitiated are disturbed by them, missing the confinements of the more populated and constricted areas to which they are accustomed. They miss the essential feature of Kansas, which is its state of mind, the product of that terrain and all it means in relation to its faithful inhabitants.

One characteristic of the state, prominently noted from the earliest periods of exploration, is the wind. Our cover illustration, Jim Hamil's rendition of the limestone monoliths in Gove County, is, indirectly, a presentation of that ubiquitous feature. For ages, the wind has worked away at the soil but has been largely confounded by the resistance of the limestone remnants of the inland-sea days. The result is that in various parts of the state, the oft-cited flatness is interrupted by these memorials to the past. Geologists ponder these structures and classify them by form or content and relate them to their incomprehensible ages and stages of that exposure.

But we can already measure changes in their "permanence" as the wind continues to erode the mineral structure. You won't really have to hurry if you want to see them, but the wind is known for its persistence and patience. It will always have more time than you do.

**HAPPY
DOCTORS' DAY!**

(March 30)

The Pathogenesis of Rationing

Some years ago, a colleague recounted his experience regarding the care of a young woman who had to be admitted to the hospital. The father of the patient admonished the physician, "Don't spare the expense, doc. Do what's necessary to get her well." The physician responded that that was his intent, but reminded the father that he had given the same instructions on the occasion of a previous illness of the patient — and the bill still hadn't been paid. The patient recovered satisfactorily, and *that* bill, at the time of the recounting, still hadn't been paid.



Probably a majority of physicians could tell similar stories, though perhaps the management systems of today have diminished the frequency of such occurrences. We have yet to see the time, however, when physicians have not written off part or all of many charges in one way or another. The well entrenched government systems are based, as is well known, on a reduced valuation of the service from the start.

Oddly, perhaps, this story was brought to mind by yet another news account of the high cost of medical care. Countless explanations, recriminations and vaunted solutions have been offered from every quarter. Still, the public, confronted with the bill, and physicians, confronted with increasing disaffection of that public and intrusive bureaucratic distractions from their medical purposes, continue to bemoan the growth of the monster and hope that yet another reexamination of the symptoms and findings will shed some curative light on the matter. Since such a solution has not appeared, we are emboldened to suggest that what we are encountering is simply a national expression of the instructions of the father in our vignette: "Don't spare the expense." Concomitantly, medical technology — and liability — burgeon exponentially, and we wonder at the expense of health care.

This has produced a mind-set in relation to medical service in which each segment is so engrossed in its own relationship, so involved in defending its own turf, that a concerted effort toward resolution, which would take the informed

cooperation of all, is lost in misdirections of each. It is as though the guidance system within a missile is set one way, the firing crew is working with a different system, and the trackers are sending still different instructions.

There seems to be a growing awareness that the admonition to spare no expense is, at some point, untenable. The parent-public, confronted with the fact that the bill must be paid in the form of higher taxes, begins to get the idea that there is a finite financial limit to the matter. There is increasing awareness that neither the government, the various third parties (whether personally- or employer-provided) nor physicians can resolve the matter alone. The multitude of news articles, seminars, foundation studies and so on are indications not of awareness of what to do, but of frustration over the seeming insolubility of the problem. There is a desperation — and alarming truth — in the increasing warnings of rationing of medical service. This rationing is taking several forms. The government is, of course, following a fiscally necessary but medically painful system of reducing its covered services. This passes the matter to the providers of financial coverage and the providers of service, the medical community. The third-party payers have a ready response: they reduce their coverage or increase their premiums — or both. This, obviously, brings the matter down to the third participant, the physician.

Physicians, as they well know, must resort to various management systems to make increasingly impersonal arrangements with the individuals with whom they (and neither of the other parties) are in direct contact, their patients. They must devise methods of patient care which exploit efficiency (a laudable goal) without sacrificing (they hope) that interpersonal awareness between themselves and their patients on which their success must be based. This, more than anything else, demarcates the role of the physician from the others involved in the process. This, in the final analysis, devolves upon the physician the responsibility to create the "rationing" system. The government washes its hands by cutting coverage and payment. The third parties increase premiums and cut services.

The physician has to say to the father, "Sorry, we can't do that. It's rationed." D.E.G.

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The Critical Issue of Cost Control

It is now quite clear that health care reform has become a national agenda item. Members of Congress are beginning to position themselves as proponents of a variety of legislative programs, each of which is touted as a bold step towards curing the ills of our nation's health care system. Some of these proposals, patterned after the Canadian health care system, will — mercifully — be buried in short order because they are inappropriate for the American public, and because they will require unrealistic fiscal enrichment of federal programs. But other emerging federal plans have more merit. Recommendations from the Pepper Commission, as articulated by Senator Jay Rockefeller, offer a well reasoned approach for responsible health care reform.



All proposals, including the AMA's Health Access America, are aimed at providing some definable health care for the more than 35 million Americans who are uninsured or underinsured. All of the plans, however, are vague as to the steps towards implementation. One reason for concern relates to the content of the "basic benefit package" to be made available to all persons, particularly those at or below the poverty level. As of this time, no one has been able to define what constitutes "basic" medical care.

The state of Oregon is making a noble attempt, having developed a sophisticated computer-generated priority system which has taken some 2,000 conditions and calculated a cost-benefit ratio for each. But the initial results were often a bit bizarre. For example, corrective breast surgery was ranked higher than treatment for an open thigh fracture. These attempts to develop value judgments with technical exercises fail; what is required are humanistic and common-sense adjustments in the open forum of public discussion and dialogue. This will be time-consuming and emotionally draining, but democratically sound, since for the first time our patients will have a hand in shaping health-care priorities.

An even more pressing issue than health care prioritization or rationing is before us now and must be addressed before any meaningful health care reform plans can emerge. Health care access must be coupled with cost containment. From

the leaders of labor and business, small and large employers, teachers and homemakers, comes a uniform and unrelenting cry that health care costs, particularly health insurance premiums, have escalated to an intolerable level. The American public is outraged at the cost of even the most basic of health insurance coverage, and many people are excluded from any coverage by arbitrary rating systems. As recently pointed out by Dr. Bill Roy, insurance companies seem to have forgotten their most fundamental purpose: to enable the individual to replace an unpredictable major expense with small, predictable payments. That is, insurance companies are (or should be) in the business of taking calculated risks for a large segment of society.

It seems to me that there are at least six ways to make a significant reduction in health care costs:

- 1 Require cost sharing by those able to pay, coupled with medical insurance with broad, community-level risk pools. This should make medical coverage available for the insurable, and affordable to those for whom individual insurance policies are too expensive.

- 2 Reduce administrative costs through elimination of "make-work" requirements in payments for delivery of health care.

- 3 Accept budget-neutral RBRVS. Funding of expensive technologic-driven medical care for the few must be weighed against meeting the primary health care needs of all, particularly pregnant women and the young.

- 4 Develop practice parameters to define quality-driven, but cost-effective, treatment plans, so as to reduce unnecessary care.

- 5 Insist that health promotion and disease prevention become a medical reality. Healthy lifestyles have enormously favorable fiscal implications.

- 6 Eliminate the practice of defensive medicine by enacting comprehensive national medical liability reform.

This final point of medical cost containment may be receiving national attention. There was an acknowledgment at a recent AMA meeting that the U.S. Congress is finally seriously considering comprehensive and meaningful tort reform, particularly through the efforts of Senator Orrin

(Continued on page 67.)



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Notification from the PRO

WAYNE T. STRATTON, J.D.,* *Topeka*

A recent experience by a Kansas physician underscores the importance of a prompt response to notifications from the PRO.

While the notification will bear the heading: NOTIFICATION OF POTENTIAL QUALITY CONCERN, it will be accompanied by a form containing handwritten notes in quite an informal style. The notification indicates that the PRO will consider additional information if submitted within 30 days.

Some of the facts the form does not mention, but which exist, are:

1 Points will be assigned to the physician, based upon the PRO's determination of the severity level.

2 The PRO will conduct an ongoing profiling of the physician, with an accumulation of the points.

3 Action by the PRO may range from education, intensified review or other interventions, to coordination with licensing and accreditation bodies and sanctions. The latter two actions may be taken for an accumulated score of 25 points.

4 There is no right to a hearing or appeal unless sanctions are imposed.



What does it mean?

5 Information about the physician's profile will be made available to hospitals.

Printed on the form is a notation: "SEVERITY LEVEL: NO OA I II III." These abbreviations refer to the initial determination made by the reviewer. Level I is medical mismanagement without potential for significant adverse effect, Level II has the potential for significant adverse effect, and Level III is medical mismanagement with significant adverse effect.

The significance of the number checked will easily escape a casual reader. *A Level III determination assigns 25 points to the physician.* Alice G. Gosfield, in her chapter in the *1989 Health Law Handbook*, commented: "A practitioner or provider could be referred to a licensure agency for potential loss of license based on a single case merely reviewed internally by a PRO which is at some risk to produce quality-relevant notches in its performance belt."

Unpleasant as the thought may be, it is obvious the future holds increased regulation and supervision of medical care. Currently, KFMC reviews 4 to 5 potential Level III determinations monthly. Undoubtedly, this number will increase.

Physicians must be sensitive to the potential seriousness of a PRO notification. Prompt and detailed response, both orally and in writing, should be made. Such response should include references to texts and corroborative and supportive information from colleagues.

Send
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Medicina et Lex Topics
to
Wayne Stratton, J.D.
(address at right)

*KMS Legal Counsel.

Comments appearing herein are not intended as a substitute for legal analysis or advice. Answers to legal questions depend largely upon the particular facts of a case. The reader is urged to consult an attorney for answers to specific legal questions.

These comments do not necessarily represent the views of KANSAS MEDICINE, or the Kansas Medical Society. For further information, contact Mr. Stratton, 515 S. Kansas, Topeka, KS 66603, 1-800-332-0248.

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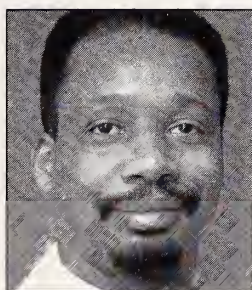
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Radioactive Waste Disposal

To the Editor:

The December 1990 issue of KANSAS MEDICINE contained the article "Radioactive Waste Disposal: Your Help Is Needed" (pp. 312-14), encouraging physicians to become involved in efforts to establish disposal facilities for low-level radioactive waste. The State of Kansas and several other states have entered into an agreement with the State of Nebraska to receive low-level radioactive waste. The establishment of this multi-state pact has been underway for several years, and in January I was told by a representative of the Kansas Department of Health & Environment that the finalization of the agreement with Nebraska is on schedule and should be in place by the 1993 deadline.

Physicians should be aware of the federal requirements and informed so they can respond to possible inquiries, but I do not believe there is a need for physicians in Kansas to proceed with actions recommended in the article. Charles Konigsberg, Jr., M.D., M.P.H., Director, Division of Health, Kansas Department of Health & Environment, should be able to provide information concerning the pact with Nebraska, since his agency is in charge at the State level.

Fred E. Tosh, M.D., M.P.H.
*Director, Wichita-Sedgwick County
Department of Community Health*

Dr. Konigsberg adds:

Kansas is a member of the Central Interstate Low-Level Radioactive Waste Compact, along with the states of Nebraska, Oklahoma, Arkansas and Louisiana. The Secretary of Health and Environment, Stanley Grant, Ph.D., is Kansas' Commissioner on the Compact Commission. Nebraska has been chosen to host the Compact's first low-level radioactive waste disposal facility and has selected a site for the facility in Boyd County. The company chosen to construct and operate the facility, U.S. Ecology, has submitted to the State of Nebraska an application for a license to build and operate an above-ground concrete disposal facility at the Boyd County site. Review and evaluation of the license application is currently under way by the State of Nebraska, as well as the other Central Compact states.

The milestones contained in the Low-Level Radioactive Waste Policy Amendments Act of 1985

(PL 99-240) necessitate that the facility in Nebraska be operational by January 1, 1993. Although the Compact member states are included, the design of the facility is primarily up to the host state. The facility will be designed for a 30-year operational lifetime.

I would agree with Dr. Tosh's assessment and recommendations. I would encourage physicians to keep themselves informed regarding low-level radioactive waste disposal issues and the development of the regional disposal facility. However, development of the Central Interstate Compact facility appears to be progressing on schedule, and I do not believe there is a need for physicians in Kansas or other Central Interstate Compact states to proceed with the actions recommended in the article.

Charles Konigsberg, Jr., M.D., M.P.H.
*Director, Division of Health
Kansas Department of Health & Environment*

(Editor's Note: Additional information regarding the activities of the Central Interstate Low-Level Radioactive Waste Compact Commission may be obtained from the Division of Health, Department of Health & Environment, Landon State Office Building, Topeka, KS 66612-1290.)

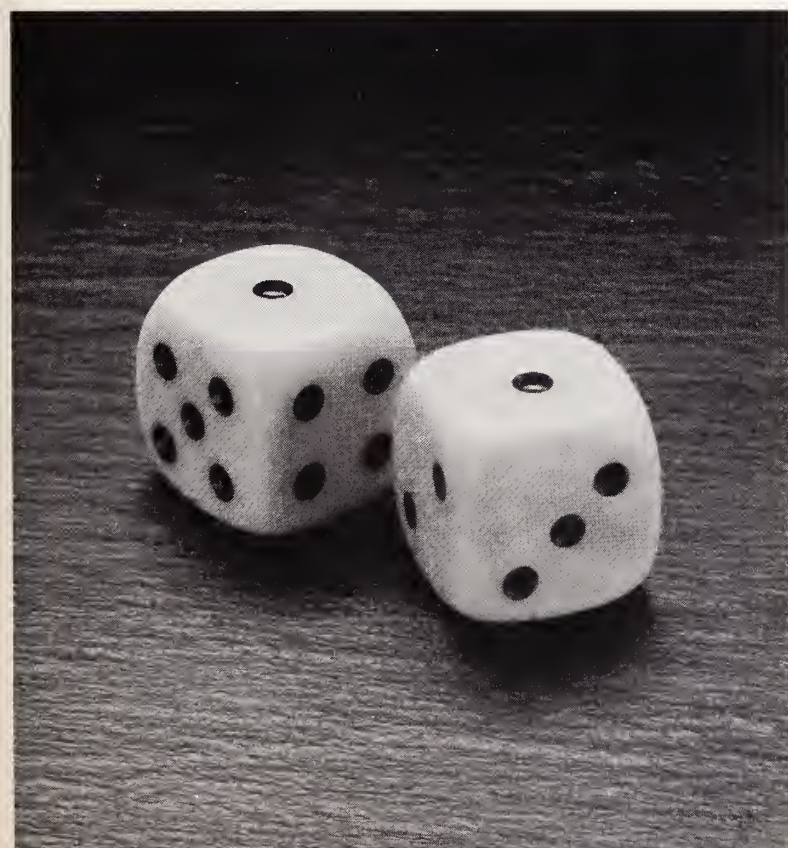
PRESIDENT'S MESSAGE

(Continued from page 62.)

Hatch. And so, a concern in health care delivery that has been recognized and discussed in recent years by an increasing number of health care providers and consumers in Kansas is now being considered at the national level. This carries some potential danger, however, since politicians do not have an untarnished record in the arena of health care. Fortunately for physicians and for our patients, the AMA has developed the Health Access America plan, which is both comprehensive and responsible, and which addresses the critical issue of cost containment. It is but one of many approaches, but it deserves to be given serious consideration.

The need for health care reform is no longer debatable; only its form of implementation is in question. Physicians need to join in this reform movement. Our professional well-being is at stake, and our actions now will determine the course of medicine for some time into the future.

Joseph E. Week, M.D.



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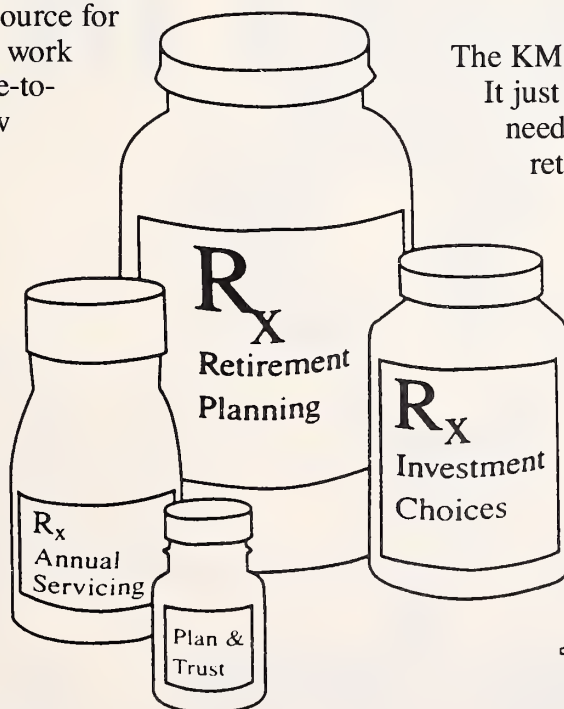
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Happy Doctors' Day!

With best regards,

Jiggy Jee

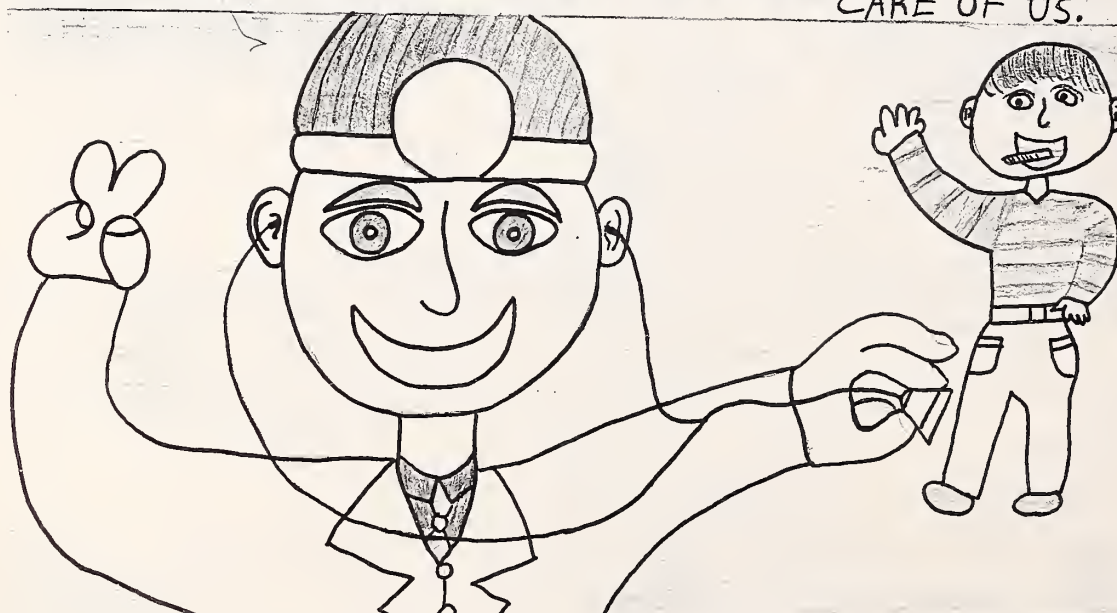


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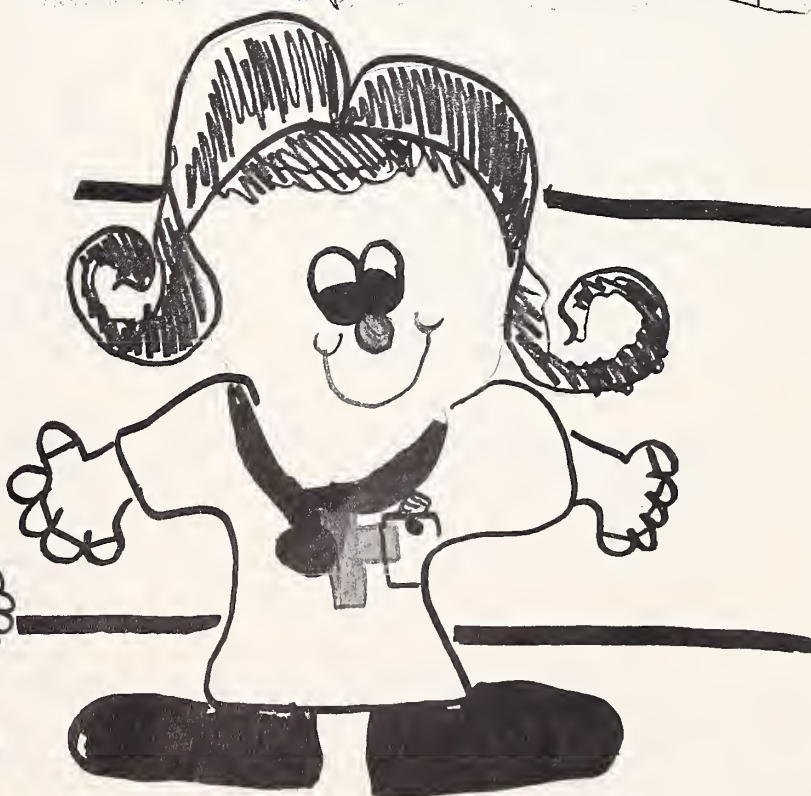
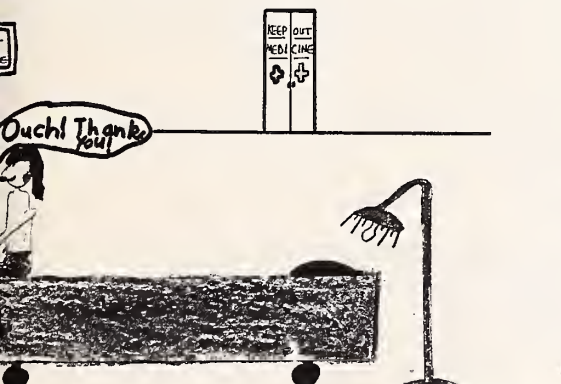
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Urokinase Infusion in Total Occlusion of Peripheral Vascular Disease

JERRY G. GASTON, D.O., PRONAB K. SENSARMA, M.D., AND
SULEMAN SADIQ, M.D.,* *Wichita*

The course of 23 patients who underwent intra-arterial thrombolytic therapy, for either occluded grafts or native vessel occlusions, was reviewed. Eighteen of the 23 patients had complete lysis, whereas one had partial lysis. Only four patients had unsuccessful thrombolysis. Thrombolytic therapy consisted of a continuous urokinase (UK) infusion of 2,000 u/min (120,000 u/hr) for 2–6 hours, after which the dose was adjusted according to angiographic studies. The majority of infusions were decreased to 1,000 u/min (60,000 u/hr) following the first angiographic demonstration of antegrade flow. Thrombolytic therapy is time-consuming and expensive, but in certain patients it offers an excellent alternative to surgical intervention.

Introduction

The use of thrombolytic therapy in peripheral vascular disease is becoming increasingly popular with the introduction of newer thrombolytic agents and invasive techniques. UK has now become the preferred agent for intra-arterial fibrinolytic infusion therapy for peripheral vascular disease. UK is a superior and safer fibrinolytic agent than streptokinase (SK) because it is a human protein and a direct plasminogen activator complex (Figure 1). UK is cleared rapidly by the liver. It has a half-life that is relatively short, averaging 20 minutes or less. Fletcher and associates demonstrated the possibility of using UK as a human thrombolytic agent in 1965.

Patients

From April 1988 to May 1990, with the majority

of patients presenting from May 1989 to May 1990, 23 patients underwent thrombolytic infusions for occlusive arterial disease. These patients included 12 men and 11 women, with an age range of 43 to 84 years old. Of the 23 patients, nine had femoral-popliteal graft occlusions, and the remaining 14 had native vessel occlusions. Fourteen of the patients had a history of peripheral vascular disease, and nine had a prior femoral-popliteal bypass graft in place. All patients presented with an ischemic leg or impending ischemia.

Technique

Each patient, before undergoing thrombolytic therapy, had an angiographically demonstrable vascular occlusion. Baseline laboratory data were obtained on the day of the procedure. The patient was brought to the angiography lab, where monitoring of vital signs continued throughout the procedure. Patients were lightly sedated with Valium or Versed. Then, under local anesthesia, vascular access was obtained, using the Seldinger technique in either the contralateral or ipsilateral femoral artery. A 5-French straight non-side port catheter was placed through a 6-French sheath introducer. Through this sheath, the catheter was then advanced to the level of the occlusion with

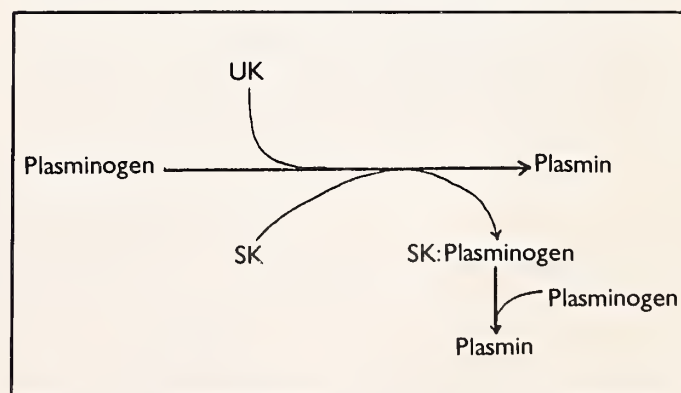


Figure 1. Activation of plasminogen by UK is direct. The activation of SK involves the initial formation of a streptokinase-plasminogen complex which converts additional plasminogen to plasmin.

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The authors wish to thank Phil Escareno for his expertise in the angiography lab, Dan Baldi, D.O., for his assistance in the care of the patients, the ICU staff for their continued patience and Deanna Rather for her assistance in the preparation of this manuscript.

angiographic guidance. An infusion of UK was started through the non-side port catheter at a rate of 2,000 u/min (120,000 u/hr). A 5,000 u bolus of heparin was given in the angiography lab, and a continuous drip at 1,000 u/hr was infused via a systemic intravenous line. Activated partial thromboplastin times were drawn to maintain the heparinization at 1½ to 2 times normal. The patient was then transferred to the intensive care unit, where close observation was carried out. Vital signs, Doppler pulses, puncture sites, and appearance of the extremity were all closely observed. The first post-procedure arteriogram was obtained 6 hours later, and the dose of UK was adjusted according to the rate of fibrinolysis. If this arteriogram failed to demonstrate any significant amount of fibrinolysis, then the UK infusion was continued at 2,000 u/min (120,000 u/hr). If significant fibrinolysis was demonstrated, then the UK infusion was decreased to 1,000 u/min (60,000 u/hr). Arteriograms were then performed every 10 to 16 hours until complete clot lysis occurred, or until another therapeutic option was chosen. If, after 24 hours, no clot lysis was demonstrable, the UK infusion was discontinued, and other options were carried out.

Successful thrombolysis was defined as either complete lysis with restoration of blood flow or partial lysis, which was simply improvement of blood flow. Success was also defined as the avoidance of an amputation or bypass graft.

Results

Of the 23 patients treated with UK for occluded grafts or native vessel occlusions, 82.6% (19/23) had successful thrombolysis, 18 had complete lysis, and one demonstrated partial lysis. Therefore, overall there was a 17.4% (4/23) failure rate. Native vessel occlusions had a success rate of 78.6% (11/14); complete lysis in 10 of the 11 successful cases, and partial lysis in one. There were nine graft occlusions. Eight were completely success-



Figure 2. A 23-cm angiographically demonstrable, completely occluded right superficial femoral lesion.

ful, and one was unsuccessful and required an embolectomy. Amputation was required in two patients who underwent unsuccessful fibrinolysis, and two others required embolectomies (Table 1).

Conventional angioplasty was performed in a number of patients where, following UK infusion, skip lesions were demonstrated by angio-

TABLE 1
SUCCESS RATE OF THROMBOLYSIS WITH UK
% OF PATIENTS

	Partially	Successful Completely	Unsuccessful
Graft	0/9 (0%)	8/9 (89%)	1/9 (11.1%)
Native vessel	1/14 (7.1%)	10/14 (71.4%)	3/14 (21.4%)
Total	1/23 (4.5%)	18/23 (78.3%)	4/23 (17.4%)
	19/23 (82.6%)		

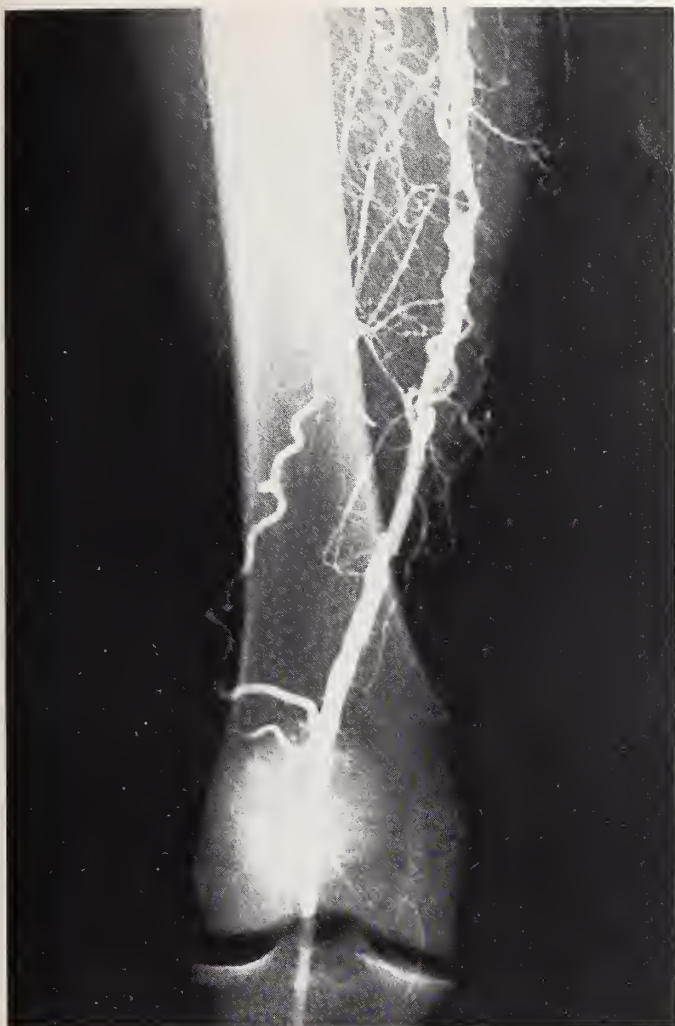


Figure 3. Recannulization of occluded vessel following infusion of UK. Balloon dilatation was performed for multiple skip lesions following UK infusion.

grams. Excellent results were obtained with this technique (Figures 2 and 3). Short-time follow-up of 1 to 2 months with angiograms demonstrated the vessels to be patent with good runoffs.

Minor hemorrhage continues to be the most significant problem associated with the infusion of thrombolytic agents. Most bleeding occurs at the puncture site and is easily controlled by direct pressure. Embolization, renal failure, cerebrovascular accident, skin rash and infection are a few other possible complications. Minor hemorrhage was the only complication we encountered.

Conclusion

Thrombolytic therapy plays a definite role in the treatment of peripheral vascular occlusions, for both grafts and native vessels. Our success rate of 82.6% compares with that of other studies involving urokinase as the thrombolytic agent. Complications were rare with our use of UK. No

deaths were encountered or transfusions required. This was attributable to the close monitoring in the ICU setting of Doppler pulses, vital signs and appearance of the extremity, concomitant heparin infusion, which helped decrease the incidence of clot formation on the infusion catheter, repeat arteriograms and cessation of therapy when indicated. This again illustrates the advantage of urokinase over streptokinase. Serum fibrinogen levels were not routinely followed, but have been added to the new protocol established for the infusion of UK. Long-term results of high-dose UK remain to be studied, but short-term follow-up of 1 to 2 months has demonstrated excellent results by arteriography.

Overall, thrombolytic therapy with urokinase proved to be of great benefit in treating patients with intra-arterial occlusions, both grafts and native vessels. The continued use of UK and percutaneous transluminal angioplasty offers another option to patients with intra-arterial occlusions.

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OPERATION DESERT STORM

KMS Members Went from Midwest to Mideast

As Operation Desert Shield escalated into Operation Desert Storm, 12 members of the Kansas Medical Society were called up for active duty, and nine of them were sent overseas. Seven of these physicians went to Saudi Arabia and two to Bahrain. The three remaining doctors were sent to Texas, Oklahoma and Ohio. Most of the 12 physicians were called up in January, and all had been by mid-February, though for some it was several weeks before they were deployed to the Middle East.

The following KMS members were called up for active duty:

Donald R. Brada, *Wichita*
Jimmie L. Browning, *Clay Center*
Hal E. Copple, Jr., *Topeka*
Michael J. Keyes, *Wichita*
Thomas G. Mathews, *Garden City*
Jon M. McMillan, *Dodge City*
Joseph E. McMullen, *Hutchinson*
Ambrosio P. Mendiola, *Pittsburg*
Michael L. O'Dell, *Kansas City*
C. Stewart Reeves, *Fort Scott*
F. Ronald Seglie, *Pittsburg*
Wallace N. Weber, *Hays*

They range in age from 40 to 58. (According to the army surgeon general's office, medical personnel are accepted until the age of 65, and must retire at 67.) The KMS-member physicians represent the following specialties: Family Practice (3), Psychiatry (2), Internal Medicine (1), Emergency Medicine (1), General Surgery (1), Dermatology (1), Obstetrics & Gynecology (1), and Pediatrics (1).

Lt. Col. Hal Copple, whose peacetime specialty is Pediatrics, was with the 410th Evacuation Hospital in Saudi Arabia. In a telephone call to his wife, Lynne, on February 21 (two days before the ground war began), he reported that the 410th was fully equipped to handle ground war casualties, and that morale within the unit was high, despite the bleak desert environment. He assured his wife that he felt safe, although she could hear explosions in the background as they talked.

Meanwhile, back at home, the KMS Auxiliary, in conjunction with the AMA Auxiliary, was doing all it could to ease the loneliness and anxiety of the deployed physicians' spouses. Special net-

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Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

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- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Hypersensitivity reactions have been reported in about 1.5% of patients and include morbilliform eruptions (1 in 100), pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions have been reported with the use of Ceclor. These are characterized by findings of erythema multiforme, rashes, and other skin manifestations accompanied by arthritis/arthralgia, with or without fever, and differ from classic serum sickness in that there is infrequently associated lymphadenopathy and proteinuria, no circulating immune complexes, and no evidence to date of sequelae of the reaction. While further investigation is ongoing, serum-sickness-like reactions appear to be due to hypersensitivity and more often occur during or following a second (or subsequent) course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults with an overall occurrence ranging from 1 in 200 (0.5%) in one focused trial to 2 in 8,346 (0.024%) in overall clinical trials (with an incidence in children in clinical trials of 0.055%) to 1 in 38,000 (0.003%) in spontaneous event reports. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy; occasionally these reactions have resulted in hospitalization, usually of short duration (median hospitalization = two to three days, based on postmarketing surveillance studies). In those requiring hospitalization, the symptoms have ranged from mild to severe at the time of admission with more of the severe reactions occurring in children. Antihistamines and glucocorticoids appear to enhance resolution of the signs and symptoms. No serious sequelae have been reported.
- Stevens-Johnson syndrome, toxic epidermal necrolysis,

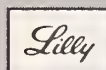
and anaphylaxis have been reported rarely. Anaphylaxis may be more common in patients with a history of penicillin allergy.

- Gastrointestinal (mostly diarrhea): 2.5%
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonía, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1% and, rarely, thrombocytopenia and reversible interstitial nephritis.

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- Slight elevations in hepatic enzymes.
- Transient lymphocytosis, leukopenia, and, rarely, hemolytic anemia and reversible neutropenia.
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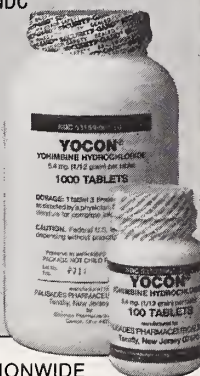
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In Kansas, county auxiliaries found special ways to express their care and concern. For example, in February the Shawnee County Medical Auxiliary sponsored an international dinner for which the food was prepared by the foreign-born members. The event raised \$590, which was spent on gift certificates for phone calls to loved ones overseas, and on trees and a plaque in honor of the Shawnee County Operation Desert Storm physicians. The trees and plaque will be installed at the new headquarters building of the Kansas Medical Society when it is built. The Shawnee County Auxiliary has also arranged for a feature story in the Topeka newspaper on Doctors' Day.

While on active duty, these KMS members are not required to pay their medical society dues. Their professional liability insurance companies waived premiums for their malpractice insurance during this time. The Kansas Medical Society is proud of its members who bravely served their country in this war, and joins all Kansans in wishing them a safe return home.

If you are aware of a KMS member who participated in Operation Desert Storm and who is not listed here, please contact Susan Ward at KMS, 800-332-0156 or 913-235-2383.

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Acute mitral regurgitation due to rupture of some portion of the mitral apparatus leads to a marked increase in the left atrial pressure during ventricular systole. The Swan-Ganz catheter records a large or even "giant" V wave from the wedge position. The V wave, which may resemble the systolic wave recorded from the pulmonary artery, occurs later with a peak which usually follows the T wave of the electrocardiogram (figure 1).

Severe mitral regurgitation may even lead to retrograde flow of arterialized blood back into the pulmonary arterial bed, leading to a bifid pulmonary artery wave form and oxygen saturations suggesting an intracardiac shunt.

Large V waves can also be recorded from the wedge position when the left atrium is noncompliant and distended in congestive failure of any etiology.

Ventricular Septal Defect

Rupture of the interventricular septum usually complicates inferior myocardial infarction and leads to a marked elevation in the right atrial pres-

sure, and to the presence of arterialized blood in the right ventricle and pulmonary artery.

If blood samples obtained from the high and low right atrium are averaged, the saturation of the averaged specimens usually exceeds that of the pulmonary artery by more than 10%.

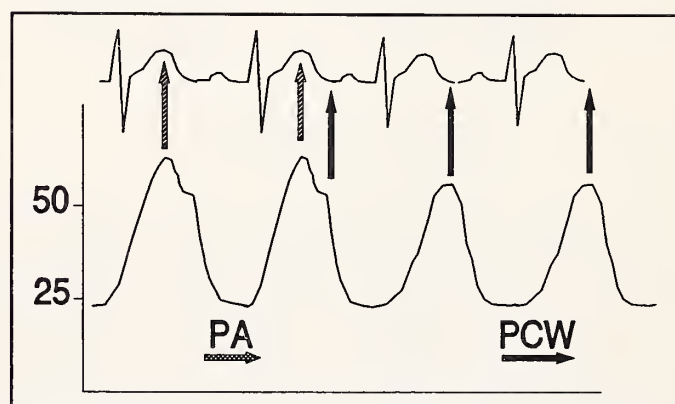


Figure 1. Severe mitral regurgitation. As catheter is advanced from pulmonary artery to pulmonary capillary wedge recording sites, the pulmonary artery pressure wave (hatched arrows) is replaced by a prominent, but delayed, regurgitant wave (solid arrows).

Right Ventricular Infarct

The upper normal limit for the mean right atrial pressure (8 mm Hg) is about half of the upper limit for the pulmonary capillary wedge pressure (16 mm Hg). When an inferior myocardial infarction is complicated by extensive septal and right ventricular damage, the right ventricular mean diastolic pressure is elevated, and this is reflected in an elevated right atrial pressure which may equal or exceed the wedge pressure. In the presence of a patent foramen ovale, a mean right atrial pressure which is higher than the left atrial pressure can lead to severe systemic arterial desaturation, which is difficult to explain if the hemodynamics have not been measured.

Since the left ventricle is also involved, the wedge pressure is usually elevated and the patient is hypotensive because the failing right ventricle cannot generate adequate force to maintain the

*Associate Professor, Department of Medicine, University of Kansas School of Medicine-Wichita

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cardiac output. A narrowed pulse pressure from the pulmonary recording site may obscure the difference between the pulmonary arterial and wedge pressure tracings.

Since biventricular failure may lead to equalization of right- and left-sided filling pressures, other findings are required to distinguish between right ventricular infarction and pericardial tamponade, which can also complicate myocardial infarction. In right ventricular infarction, the X and Y descents of the right atrial wave-form are exaggerated, and inspiration leads to an increase in mean right atrial pressure. The changes associated with tamponade are opposite in direction and can be confirmed echocardiographically.

Comments

Primary physicians are often reluctant to utilize the Swan-Ganz catheter for diagnosis and monitoring. This is based, in part, on a concern over possible complications of the procedure.

When right heart catheterization is performed via the femoral vein, significant complications are virtually nil. Major problems, such as sepsis and pulmonary embolism, are the result of prolonged monitoring.

When used for diagnosis, the information obtained can be used to determine whether or not the risks of continued hemodynamic monitoring are justified by the potential benefits. If not, the catheter can be removed.

REFERENCE

1. Sharkey SW. Beyond the wedge: Clinical physiology and the Swan-Ganz catheter. *Am J Med* 1987;83:111-22.

Notes & Quotes

NEWS FOR AND ABOUT KMS MEMBERS

MARCH 1991

Doctors' Day Is Now a National Observance

March 30 is Doctors' Day, and George Bush, for the first time, has designated it National Doctors' Day. The occasion was first observed in Barrow County, Georgia, in 1933, to commemorate the anniversary of the date in 1942 when Dr. Crawford W. Long first used ether as an anesthetic agent in a surgical technique. The observance has gradually been adopted throughout the country to honor physicians. The official flower is the red carnation.

MEDISERVE Scholarship Program

The MEDISERVE Scholarship Program is sponsored by the Kansas Medical Society and the Kansas Farm Bureau. Three scholarships of \$2,000 each will be granted to full-time medical students annually. Students granted scholarships may reapply for additional scholarships each year of medical school training. Recipients are required to complete a primary care residency program (Family Practice, Internal Medicine, Pediatrics, General Surgery, Obstetrics/Gynecology) and establish a medical practice in a Kansas community with a population of less than 12,000. The service commitment shall be one year for each scholarship granted.

If a recipient does not meet the requirements of this program following graduation, the scholarships shall be converted to loans, plus 15% annual interest accrued from the date the scholarship was granted, repayable over a five-year period.

Scholarships are based upon written application and personal interview. Applications and information may be secured by writing MEDISERVE, 1300 Topeka Avenue, Topeka, Kansas 66612. The application deadline is May 1.

Medical "Good Samaritans" Run Afoul of Government Regulations

Physicians who have offered discounts on medical care to the families of military personnel have broken the law and must cease to offer these special programs. Physicians in several parts of the country, in an effort to show support for Desert Storm, offered to waive the copayments and deductibles that patients pay under the CHAMPUS program. But because CHAMPUS is a cost-sharing program under the law, waiving the cost-sharing portion of the program is illegal, according to CHAMPUS spokesmen, who added that providers who continue to waive copayments could be seen as engaging in a "pattern of abuse" that would subject them to civil penalties to be determined by a court. There is, however, no legal precedent.

Controlled Substances Is Subject of Conference

It is not too late to register to attend the conference "Controlled Substances: Use and Abuse," which will be held at the Wichita Airport Hilton on Saturday, April 6,

1991, from 9:00 a.m. to noon. The cost, with three hours of Category I CME credit, is \$30. To register, call KMS at 800-332-0156 or 913-235-2383.

Lead from Crystal Vessels May Leach into Liquids They Contain

Recent tests reported in The Lancet and in The Journal of Pediatrics show that lead crystal bottles and decanters may not be safe containers for beverages. Lead from these containers can leach into the contents, and it appears that the longer the liquid remains in the bottle, the higher the concentration of lead. Two crystal manufacturers, Steuben and Waterford Wedgwood, have stopped manufacturing certain crystal decanters, flasks and baby bottles until the results of more tests are obtained. Crystal from various countries will be studied to determine if differences in manufacturing techniques account for the leaching. Meanwhile, caution should be exercised when using crystal vessels; the researchers observed that lead levels found in alcoholic beverages stored for many years in crystal containers were comparable "to those in the notorious sweetened wines of Roman times."

Nikon Sponsors Photomicrography Competition

The Nikon International Small World photomicrography competition was created to honor excellence in photography through the microscope. Each participant may submit up to three 35mm transparencies, with magnification ranging from 10X to 2,000X. Entries will be judged on their originality, informational content, composition, color balance and color contrast. All varieties of specimens and illumination techniques are permitted, and the use of Nikon equipment is not required. Prizes include a \$3,000 vacation trip and a selection of Nikon products. The winning photos will be exhibited during 1991 and will be featured in a Nikon calendar. The entry deadline is June 28, 1991. Submit entries to Nikon, Inc., Instrument Group, 1300 Walt Whitman Road, Melville, New York 11747. For information, call 516-547-8500.

Congratulations

...To Jack Walker, M.D., Shawnee Mission, who has been named Chairman of the KU Medical Alumni Association fund-raising committee. The goal of the committee is to increase the percentage of medical alumni participation in all aspects of charitable giving to the school.

...To Daniel K. Roberts, M.D., Wichita, who has been honored by HCA Wesley Medical Center with a \$250,000 gift to the KU Endowment Association. The gift will establish a named professorship in the Wichita campus' department of obstetrics and gynecology, of which Dr. Roberts is the founding chairman.

...And to Rodney L. Jones, M.D., Wichita, who has recently been certified by the American Society of Addiction Medicine as knowledgeable and expert in diagnosis and treatment of patients with chemical dependence. Nationally, there are now 2,320 ASAM-certified physicians.

Looking Ahead to April

Several observances of interest to physicians take place during the month of April: Cancer Control Month, sponsored by the American Cancer Society, Attn: Joann Schellenbach, 1180 Avenue of the Americas, New York, NY 10036.

National Alcohol Awareness Month, and Alcohol-Free Weekend, Public Relations Department, National Council on Alcoholism and Drug Dependence, 12 West 21st Street, New York, NY 10010.

National Child Abuse Prevention Month, National Committee for Prevention of Child Abuse, Public Awareness Department, 332 S. Michigan Ave., Suite 1600, Chicago, IL 60604; 312-663-3520.

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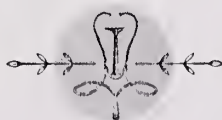
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Benign Breast Disease

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THERAPY THAT MAY BE AS SILENT AS HYPERTENSION ITSELF

VASOTEC is generally well tolerated and not characterized by certain undesirable effects associated with selected agents in other antihypertensive classes.

VASOTEC is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor. A diminished antihypertensive effect toward the end of the dosing interval can occur in some patients.

For a Brief Summary of Prescribing Information, please see the last page of this advertisement.

FOR MANY
HYPERTENSIVE PATIENTS
ONCE-A-DAY

VASOTEC[®]
(ENALAPRIL MALEATE | MSD)





VASOTEC®

(ENALAPRIL MALEATE | MSD)

VASOTEC is available in 2.5-mg, 5-mg, 10-mg, and 20-mg tablet strengths.

Contraindications: VASOTEC* (Enalapril Maleate, MSD) is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

Warnings: Angioedema. Angioedema of the face, extremities, lips, tongue, glottis, and/or larynx has been reported in patients treated with ACE inhibitors, including VASOTEC. In such cases, VASOTEC should be promptly discontinued and appropriate therapy and monitoring should be provided until complete and sustained resolution of signs and symptoms has occurred. In instances where swelling has been confined to the face and lips, the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL) and/or measures necessary to ensure a patent airway, should be promptly provided.** (See ADVERSE REACTIONS.)

Hypotension: Excessive hypotension is rare in uncomplicated hypertensive patients treated with VASOTEC alone. Patients with heart failure given VASOTEC commonly have some reduction in blood pressure, especially with the first dose, but discontinuation of therapy for continuing symptomatic hypotension usually is not necessary when dosing instructions are followed; caution should be observed when initiating therapy. (See DOSAGE AND ADMINISTRATION.) Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death, include those with the following conditions or characteristics: heart failure, hyponatremia, high-dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salt depletion of any etiology. It may be advisable to eliminate the diuretic (except in patients with heart failure), reduce the diuretic dose, or increase salt intake cautiously before initiating therapy with VASOTEC in patients at risk for excessive hypotension who are able to tolerate such adjustments. (See PRECAUTIONS, *Drug Interactions* and ADVERSE REACTIONS.) In patients at risk for excessive hypotension, therapy should be started under very close medical supervision and such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart disease or cardiovascular disease in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident.

If excessive hypotension occurs, the patient should be placed in the supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses of VASOTEC, which usually can be given without difficulty once the blood pressure has stabilized. If symptomatic hypotension develops, a dose reduction or discontinuation of VASOTEC or concomitant diuretic may be necessary.

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Foreign marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

Fetal/Neonatal Morbidity and Mortality: ACE inhibitors, including VASOTEC, can cause fetal and neonatal morbidity and mortality when administered to pregnant women.

Enalapril crosses the human placenta. When ACE inhibitors have been used during the second and third trimesters of pregnancy, there have been reports of hypotension, renal failure, skull hypoplasia, and/or death in the newborn. Oligohydramnios has also been reported, presumably representing decreased renal function in the fetus; limb contractures, craniofacial deformities, hypoplastic lung development and intrauterine growth retardation have been reported in association with oligohydramnios. Patients who do require ACE inhibitors during the second and third trimesters of pregnancy should be apprised of the potential hazards to the fetus, and frequent ultrasound examinations should be performed to look for oligohydramnios. If oligohydramnios is observed, VASOTEC should be discontinued unless it is considered life-saving for the mother.

Other potential risks to the fetus/neonate exposed to ACE inhibitors include: intrauterine growth retardation, prematurity, patent ductus arteriosus; fetal death has also been reported. It is not clear, however, whether these reported events are related to ACE inhibition or the underlying maternal disease. It is not known whether exposure limited to the first trimester can adversely affect fetal outcome.

Infants exposed *in utero* to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion.

Enalapril has been removed from the neonatal circulation by peritoneal dialysis and theoretically may be removed by exchange transfusion, although there is no experience with the latter procedure.

There was no fetotoxicity or teratogenicity in rats treated with up to 200 mg/kg/day of enalapril (333 times the maximum human dose). Fetotoxicity, expressed as a decrease in average fetal weight, occurred in rats given 1200 mg/kg/day of enalapril, but did not occur when these animals were supplemented with saline. Enalapril was not teratogenic in rabbits. However, maternal and fetal toxicity occurred in some rabbits at doses of 1 mg/kg/day or more. Saline supplementation prevented the maternal and fetal toxicity seen at doses of 3 and 10 mg/kg/day but not at 30 mg/kg/day (50 times the maximum human dose).

If VASOTEC is used during pregnancy or if the patient becomes pregnant while taking VASOTEC, the patient should be apprised of the potential hazards to the fetus.

Precautions: General: Impaired Renal Function: As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including VASOTEC, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20% of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when VASOTEC has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of the diuretic and/or VASOTEC may be required.

Evaluation of patients with hypertension or heart failure should always include assessment of renal function. (See DOSAGE AND ADMINISTRATION.)

Hyperkalemia: Elevated serum potassium (> 5.7 mEq/L) was observed in approximately 1% of hypertensive patients in clinical trials. In most cases these were isolated values which resolved despite continued therapy. Hyperkalemia was a cause of discontinuation of therapy in 0.28% of hypertensive patients. In clinical trials in heart failure, hyperkalemia was observed in 3.8% of patients, but was not a cause for discontinuation.

Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with VASOTEC. (See *Drug Interactions*.)

Cough: Cough has been reported with the use of ACE inhibitors. Characteristically, the cough is nonproductive, persistent and resolves after discontinuation of therapy. ACE inhibitor-induced cough should be considered as part of the differential diagnosis of cough.

Surgery/Anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients: Angioedema. Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

Hypotension: Patients should be cautioned to report lightheadedness, especially during the first few days of therapy. If

actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

Hyperkalemia: Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia: Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

NOTE: As with many other drugs, certain advice to patients being treated with enalapril is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions: Hypotension: Patients on Diuretic Therapy: Patients on diuretics and especially those in whom diuretic therapy was recently instituted may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide close medical supervision after the initial dose for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and DOSAGE AND ADMINISTRATION.)

Agents Causing Renin Release: The antihypertensive effect of VASOTEC* (Enalapril Maleate, MSD) is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents: VASOTEC has been used concomitantly with beta-adrenergic-blocking agents, methyldopa, nitrates, calcium-blocking agents, hydralazine, prazosin, and digoxin without evidence of clinically significant adverse interactions.

Agents Increasing Serum Potassium: VASOTEC attenuates potassium loss caused by thiazide-type diuretics. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia, they should be used with caution and with frequent monitoring of serum potassium. Potassium-sparing agents should generally not be used in patients with heart failure receiving VASOTEC.

Lithium: Lithium toxicity has been reported in patients receiving lithium concomitantly with drugs which cause elimination of sodium, including ACE inhibitors. A few cases of lithium toxicity have been reported in patients receiving concomitant VASOTEC and lithium and were reversible upon discontinuation of both drugs. It is recommended that serum lithium levels be monitored frequently if enalapril is administered concomitantly with lithium.

Pregnancy: Pregnancy Category D. See WARNINGS, *Fetal/Neonatal Morbidity and Mortality*.

Nursing Mothers: Enalapril and enalaprilat are detected in human milk in trace amounts. Caution should be exercised when VASOTEC is given to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Adverse Reactions: VASOTEC has been evaluated for safety in more than 10,000 patients, including over 1000 patients treated for one year or more. VASOTEC has been found to be generally well tolerated in controlled clinical trials involving 2987 patients.

HYPERTENSION: The most frequent clinical adverse experiences in controlled trials were: headache (5.2%), dizziness (4.3%), and fatigue (3%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in controlled clinical trials were: diarrhea (1.4%), nausea (1.4%), rash (1.4%), cough (1.3%), orthostatic effects (1.2%), and asthenia (1.1%).

HEART FAILURE: The most frequent clinical adverse experiences in both controlled and uncontrolled trials were: dizziness (7.9%), hypotension (6.7%), orthostatic effects (2.2%), syncope (2.2%), cough (2.2%), chest pain (2.1%), and diarrhea (2.1%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in both controlled and uncontrolled clinical trials were: fatigue (1.8%), headache (1.8%), abdominal pain (1.6%), asthenia (1.6%), orthostatic hypotension (1.6%), vertigo (1.6%), angina pectoris (1.5%), nausea (1.3%), vomiting (1.3%), bronchitis (1.3%), dyspnea (1.3%), urinary tract infection (1.3%), rash (1.3%), and myocardial infarction (1.2%).

Other serious clinical adverse experiences occurring since the drug was marketed or adverse experiences occurring in 0.5% to 1% of patients with hypertension or heart failure in clinical trials in order of decreasing severity within each category:

Cardiovascular: Cardiac arrest; myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high-risk patients (see WARNINGS, *Hypotension*); pulmonary embolism and infarction, pulmonary edema; rhythm disturbances including atrial tachycardia and bradycardia; atrial fibrillation; palpitation.

Digestive: Ileus, pancreatitis, hepatitis (hepatocellular [proven on rechallenge] or cholestatic jaundice), melena, anorexia, dyspepsia, constipation, glossitis, stomatitis, dry mouth.

Musculoskeletal: Muscle cramps.

Nervous/Psychiatric: Depression, confusion, ataxia, somnolence, insomnia, nervousness, paresthesia.

Respiratory: Bronchospasm, rhinorrhea, sore throat and hoarseness, asthma, upper respiratory infection.

Skin: Exfoliative dermatitis, toxic epidermal necrolysis, Stevens-Johnson syndrome, herpes zoster, erythema multiforme, urticaria, pruritus, alopecia, flushing, diaphoresis.

Special Senses: Blurred vision, taste alteration, anosmia, tinnitus, conjunctivitis, dry eyes, tearing.

Urogenital: Renal failure, oliguria, renal dysfunction (see PRECAUTIONS and DOSAGE AND ADMINISTRATION), impotence.

A symptom complex has been reported which may include a positive ANA, an elevated erythrocyte sedimentation rate, arthralgia/arthritis, myalgia, fever, serositis, vasculitis, leukocytosis, eosinophilia, photosensitivity, rash, and other dermatologic manifestations.

Angioedema: Angioedema has been reported in patients receiving VASOTEC (0.2%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with VASOTEC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Hypotension: In the hypertensive patients, hypotension occurred in 0.9% and syncope occurred in 0.5% of patients following the initial dose or during extended therapy. Hypotension or syncope was a cause for discontinuation of therapy in 0.1% of hypertensive patients. In heart failure patients, hypotension occurred in 6.7% and syncope occurred in 2.2% of patients. Hypotension or syncope was a cause for discontinuation of therapy in 1.9% of patients with heart failure. (See WARNINGS.)

Fetal/Neonatal Morbidity and Mortality: In infants exposed *in utero* to ACE inhibitors the following adverse experiences have been reported: Fetal and neonatal death, renal failure, hypoplastic lung development, hypotension, hyperkalemia, skull hypoplasia, limb contractures, craniofacial deformities, intrauterine growth retardation, prematurity and patent ductus arteriosus. (See WARNINGS, *Fetal/Neonatal Morbidity and Mortality*.)

Clinical Laboratory Test Findings: Serum Electrolytes: Hyperkalemia (see PRECAUTIONS), hyponatremia.

Creatinine, Blood Urea Nitrogen: In controlled clinical trials, minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.2% of patients with essential hypertension treated with VASOTEC alone. Increases are more likely to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis. (See PRECAUTIONS.) In patients with heart failure who were also receiving diuretics with or without digitalis, increases in blood urea nitrogen or serum creatinine, usually reversible upon discontinuation of VASOTEC and/or other concomitant diuretic therapy, were observed in about 11% of patients. Increases in blood urea nitrogen or creatinine were a cause for discontinuation in 1.2% of patients.

Hemoglobin and Hematocrit: Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g% and 1.0 vol%, respectively) occur frequently in either hypertension or heart failure patients treated with VASOTEC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1% of patients discontinued therapy due to anemia.

Other (Causal Relationship Unknown): In marketing experience, rare cases of neutropenia, thrombocytopenia, and bone marrow depression have been reported. A few cases of hemolysis have been reported in patients with G6PD deficiency.

Liver Function Tests: Elevations of liver enzymes and/or serum bilirubin have occurred.

For more detailed information, consult your MSD Representative or see Prescribing Information, Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, PA 19486.

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**ABOUT OUR LOGO**

In January 1935, a new logo appeared on the cover of KANSAS MEDICINE for the first time. This device represents two stethoscopes: the original monaural type as used by Laënnec, and the modern binaural variety. The logo was designed expressly for KANSAS MEDICINE by renowned graphic designer Bradbury Thompson, a native of Topeka and friend of two former editors of the journal, Dr. W.M. Mills and Dr. Lucien Pyle. As another former editor, Dr. Orville R. Clark, wrote in January 1955, the logo "has become as much a part of the journal as any of the features on the inside and is something which is ours alone."

One might think that there was nothing more to say about spring. Obviously, it has been a recurring phenomenon for eons and has inspired poets, artists, musicians and amateur gardeners to apply their energies to its challenge. Jim Hamil's "Spring in Leawood," which appears on our cover, is a gratifying example. It combines the color, new growth and tranquility denoting the subject and makes a title all but unnecessary.

Spring's position in the seasonal sequence is a fortunate one. Whether it was bitter or mild, winter has worn out its welcome. The excesses of summer heat and humidity are not yet reality. And autumn has its points — realizing the rewards of summer efforts, if bugs, disease, drought or other weather caprices haven't had the upper hand — but it inevitably leads to winter.

Spring is usually represented allegorically as a young, shapely blond in a diaphanous gown decorated with flowers, and with a rabbit in tow. It is a well chosen representation, since it implies the seductive influences of the season on the above-mentioned gardeners. Despite years of failure, they are inspired to acquire an excess of gardening equipment and materials, convinced that *this* year they are really going to have a prize floral display or set vegetable production records. Nurserymen, garden store proprietors and discount stores welcome this horde of optimists with a willingness to provide these necessities. They encourage their victims with veiled promises of success, carefully concealing the fact that they remember the victims from last year and know they can figure on being in business another year. Perhaps the victim's next purchase will be a fence, in the event that the rabbit has responded characteristically — and disposed of large portions of the gardener's successes (if any).

Where did you think the saying "Hope *springs* eternal" came from?

Home Run

The ashes are restless and the phoenix, beginning to stir, shows signs of returning in a much different plumage. The venerated house call, now existing in a rarity warranting, on discovery, a feature story in the paper, shows signs of revival in a surprisingly appropriate form. The new version of this practice, however, bears only a generic resemblance to the old, having assumed a more sophisticated dress. In keeping with its more ambitious intent, it is being called "home care." As this implies, the traditional little black bag is considerably larger and contains a medical armamentarium unthinkable not too long ago, when such things were the exclusive province of the hospitals.



The home care phenomenon is remarkable for its degree of logic, a melding of the several medical, social and economic factors in a climate that was distinguished not too long ago by notable divisions of the now-combined elements. In fact, it can be said that the most compelling factor was the pressure for control of medical costs and the repeated demonstration that hospital utilization, whatever its medical benefits, could be a devastating experience economically. As public awareness of the rising costs has grown, the nation has realized that its one-time assumption that individuals would have (or should have had) some form of insurance — or, of course, one or another of the government programs — was unrealistic. Innovation was called for.

"Critics" and "crisis" stem from the same root, so it is not surprising that complaints should produce the catch phrase "health care crisis." Hospitals and physicians became the objects of public rancor as the assumed benefactors of the system. Beyond this, however, came an increased social sensitivity and realization that we were ripe for some alteration in health care delivery, that physicians should become more aware of the expenses to which they subjected their patients in the name of proper care, and even grudging realization on the part of the public that they might have a responsibility to give attention to those forms of behavioral habits that brought them into the system subjectively.

Meetings have been called, symposia have been held, think-tanks have pondered and reported,

foundations have been formed and have promoted study sessions and ideas.

Numerous plans have been advanced, advocating a variety of payment systems or alteration of medical service, both principles and practice. Medical practice has been put in a defensive posture as it was confronted with the "Catch-22" situation: how to provide ideal and full medical care for everyone — while reducing costs. It has become apparent to the public, perhaps, that medical miracles have, indeed, produced economic benefits but that the acceptance of these benefits into the system seemed to bring increased, not fewer, demands on the economic system. Acceptable compensation systems are elusive. In some way, the delivery of these now-mundane miracles had to be made obtainable beyond the capacity of the conventional system — or face restriction.

With a mixture of effort, imagination and necessity, the concept of taking certain procedures to the patient has evolved. Personnel at various levels in the more recognizable setting of the hospital must be reconditioned to think in terms of applying their expertise in the home setting. Equipment must be adapted to use in this unaccustomed place and the functions of various methods integrated into this unfamiliar setting. Home facilities, including families and other personal contacts, must be included. And, in recognition of the economic facts of life, methods of adequate financial support must be developed.

It is, above all, a concept that calls for serious and continuing contributions of physicians, whether they actively participate or not. It should be an extension of the customary service philosophy they proclaim: the physician should be the controller of the process, directing and integrating the services of the ancillary personnel who will be active in delivery of home care. Too often, physicians have expressed their objections to trends in medical care by either resistance or lukewarm participation. The result has been that, increasingly, medical care has come under the provision of other personnel. Physicians have been prone, in other instances, to cry out in alarm at the erosion of their authority by a form of philosophic default. The profession would be remiss if it failed to maintain control of this promising form of an age-old service in a new dress. D.E.G.

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Parting Thoughts

A backward look can be a dangerous exercise, as Satchel Page once observed, for "somebody may be catching up." Nevertheless, it seems appropriate at this time to review some of the issues and efforts of the Kansas Medical Society during my term as your president.



Certainly one of our greatest accomplishments has been the emergence of KaMMCO, our mutually owned company, as a major force in medical malpractice insurance. Now with over 750 members, representing more than one-third of the physicians practicing in Kansas, KaMMCO is exerting a new standard of insurance practice that has resulted and will continue to result in the reduction of premium costs for all physicians. Through its efficient management of the Joint Underwriters Association (JUA), KaMMCO has significantly reduced operating costs and has been active in policy development that allows our resident physicians the opportunity to participate in community medical practice. As plans take shape for redefinition of the role of the Health Care Stabilization Fund, KaMMCO is positioning itself to enter the re-insurance market, so as to provide further coverage to its members. The prudent and conservative principles which guide this company have made it a national model for physician-owned medical insurance companies.

Both KaMMCO and KMS have grown, and as a result, these organizations have run out of room. Plans are well underway for a new building in Topeka that will accommodate their growing needs, and the ground-breaking ceremonies took place on April 3. By bringing these two organizations together in one building, we increase our opportunities for future growth and symbiotic development.

Not all of our society's activities have given as satisfying a sense of accomplishment as those noted above. There remains a strong concern among our members that peer review faces major problems in its equitable implementation. Examples of arbitrary or inappropriate actions abound, and a mechanism to accomplish fair peer review in small medical communities is often difficult to achieve. Reimbursement and physician payment

issues involving the federal government continue to occupy many hours of staff time. The laudable goal of securing an appropriate level of reimbursement for Kansas physicians must never be achieved at the expense of compromising such payments by focusing them into areas of geographic or specialty self-interest.

I have written previously about the problem of recruitment of primary care physicians for our state. Despite efforts such as the Kansas Medical Scholarship Program and the Bridging Plan, the

"We have at our disposal a resource to address and eventually correct many of the problems we face."

areas of need continue to be underserved. A national symposium, sponsored by the American Medical Student Association, was recently held in Kansas City on the subject of financing medical education. It was pointed out that our medical students finish their studies for the M.D. degree with a debt accumulation of over \$40,000, and interest starts to accrue immediately after graduation. Even accounting for inflation of the dollar, our students are facing costs of medical education which have increased by up to 400% over the past 30 years. It takes no special insight to see why fewer students are selecting careers in the lower-paid primary care specialties. Indeed, such debt accumulation may be responsible for the downturn in medical school applications over the past several years, especially by students from minority and low-income families. The Kansas Medical Society must find new, bold and innovative plans to meet the continuing problem of maldistribution of medical manpower in Kansas.

It is quite justifiable to express our concerns about the future of medicine in Kansas. But one indisputable fact must be acknowledged. We have at our disposal a resource to address and eventually correct many of the problems we face. This

(Continued on page 111.)

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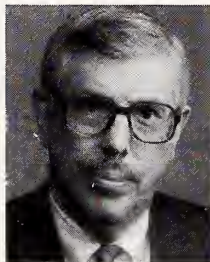
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Third-Party Payers and the Physician's Duty of Confidentiality

WAYNE T. STRATTON, J.D.,* *Topeka*

The origin of the confidential relationship is unknown. However, it was expressed in the Hippocratic oath as: "Whatever, in connection with my professional practice, or not in connection with it, I see or hear in the life of men, which ought not be spoken abroad, I will not divulge, as reckoning that all such should be secret."



The report of the Council on Ethical and Judicial Affairs of the American Medical Association, No. XXVI, June 1990, states, "The patient has a right to confidentiality. The physician should not reveal confidential communications or information without the consent of the patient, unless provided for by law or by the need to protect the welfare of the individual or the public interest."

Kansas does not have a comprehensive act regarding medical records. The obligation to maintain records and the physician's duties with regards to maintaining the confidentiality of patient communications must be culled from various statutes and regulations, as well as from case law.

K.S.A. 60-427 (4) provides:

'Confidential communication between physician and patient' means such information transmitted between physician and patient, including information obtained by an examination of the patient, as is transmitted in confidence and by a means which, so far as the patient is aware, discloses the information to no third persons other than those reasonably necessary for the transmission of the information or the accomplishment of the purpose for which it is transmitted.

The Kansas Supreme Court has observed that, while at common law there was no physician/

Do I need an authorization to release records to an HMO?

patient privilege, most states, including Kansas, have adopted such a privilege by statute. "The statute precludes physicians from disclosing confidential communications between them and their patients. Thus, the confidentiality of the physician/patient relationship is a matter of strong public policy in Kansas."

Because of the confidential relationship which exists between a patient and a physician, the court has imposed the duty of a fiduciary upon a physician. Various actions have successfully been brought against physicians for breach of confidential communications, breach of fiduciary obligations, and defamation. The Restatement of Torts recognizes various types of lawsuits brought for invasion of privacy, invasion of the right of seclusion and for giving publicity to private life. Currently, plaintiff attorneys in medical malpractice and other personal injury litigation are insisting that treating physicians are not allowed to visit with counsel for the defendant without express authorization of the patient/plaintiff. Their position has been upheld in some cases and rejected in others.

In certain instances, records require special handling and may not be released, except upon specific authorization. These relate generally to alcohol and drug abuse and psychiatric records. Generally, medical records may not be released without a court order with a subpoena or a signed authorization of the patient or representative of the patient.

With the advent of Medicare/Medicaid, retrospective reviews of care became common. These

(Continued on page 111.)

*KMS Legal Counsel.

Comments appearing herein are not intended as a substitute for legal analysis or advice. Answers to legal questions depend largely upon the particular facts of a case. The reader is urged to consult an attorney for answers to specific legal questions.

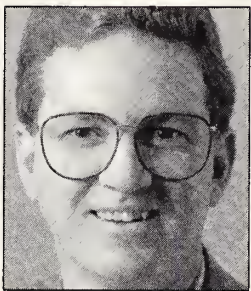
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A Look Backward — And Forward

Dear Physicians:

As the auxiliary year draws to a close, I realize one of the things I will miss is sitting in on the Kansas Medical Society Executive Committee meetings. From that vantage point, I have learned a lot. I found that KMS President Joseph C. Meek, Jr., M.D., Executive Director Jerry Slaughter and other board members worked very hard on behalf of the physicians in Kansas. And Dr. Jimmie Gleason's leadership and efforts in creating KaMMCO have saved Kansas physicians millions of dollars in insurance premiums. I hope *every* physician in Kansas will join the Kansas Medical Society!

In our capacity of auxiliary to our medical society, we make a consistent effort to understand current issues in medicine. At our fall conference, Dr. Gleason gave a comprehensive update on KaMMCO and legislative issues to the auxiliary members. At the winter meeting, Jerry Slaughter talked to us about access to health care and possible changes in the future. Chip Wheelen, KMS Director of Public Affairs, provided a briefing on medically related issues that would come before our legislators, and Associate Executive Director Val Braun spoke about the auxiliary's supporting role in organized medicine.

We are looking forward to hearing Dr. Meek at our annual meeting in May. He will be the featured



speaker for the opening of our House of Delegates. I hope you will join us at the AMA-ERF Dinner and Auction during the annual meeting. This event will be held on Thursday, May 2 at 6:30 p.m., at the Crestview Country Club in Wichita. Entertainment will be provided by the Music Theatre of Wichita.

Last Christmas, in an effort to support the KMS initiative of promoting access to health care, we raised \$2,244 for the Caring Program for Children. [See article on page 96. — Editor] In addition to support for your programs, our auxiliary will continue to emphasize AMA-ERF, membership, legislation and the health projects.

The decline in our membership in recent years is a great concern. Less than one-half of KMS physicians' spouses have joined the medical auxiliary. Will you help us to recruit more members?

We are looking forward to a new year with Joy Bell of Salina as our president. I am confident that under her leadership the Kansas Medical Society Auxiliary will have a great year.

Thank you for giving me this page on which to communicate with you. I have always appreciated your support, and I will try my best to continue to work for the benefit of our organizations.

Sincerely yours,

Joy Bell

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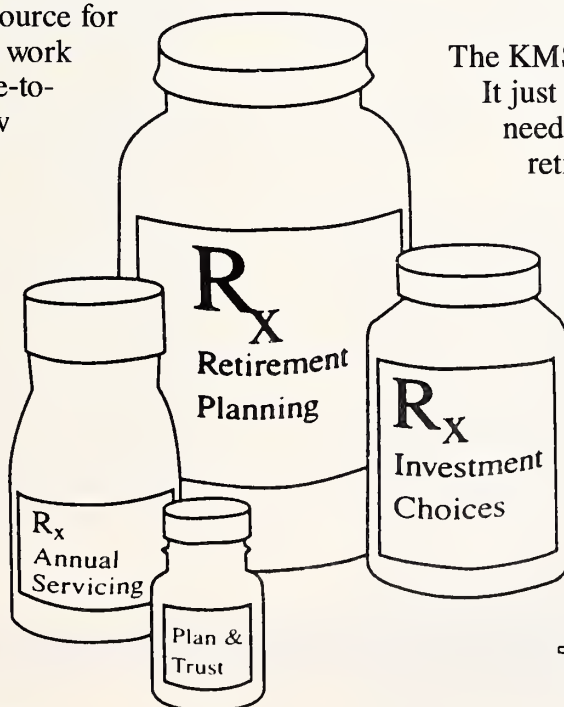
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- Customized retirement planning . . . we'll design, implement, and administer it
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- Access to diversified investment products that best fit your needs

Cohen, Curtis and Associates, the recommended retirement planning source for members of KMS, is ready to work with you, one-on-one and face-to-face. We can help you see how flexible your retirement plan can be, helping you choose from a wide range of services and products, whether your practice is organized as a corporation, partnership, or sole proprietorship.

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Drugs should be referred to by generic names; trade names may follow in parentheses if useful. All **units of measure** must be given in the metric system.

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Health Care Coverage for Uninsured Children

The Caring Program for Children has survived its infancy and is now a growing two-year-old. It exists to provide coverage for basic, preventive health care free of charge to needy children in three pilot counties: Ellis, Sedgwick and Shawnee. The program was developed by the Kansas Medical Society, the Kansas Hospital Association and Blue Cross and Blue Shield of Kansas, with funds administered by the latter organization.

To date, more than 500 children have been helped by The Caring Program. But studies indicate that approximately 9,000 more children in the three pilot counties alone are uninsured, and it is estimated that 32,000 Kansas children have no health care insurance. So far, more than 1,816 services have been provided since the program's inception, an average of 4.5 per child per year. These services were provided to 43 children in Ellis County, 219 in Sedgwick County and 152 in Shawnee County.

Funding for the program is obtained through private donations from groups and individuals, and through the generosity of health care providers who agree to accept reduced payments for their services. By the end of 1990, \$176,100.42 in cash contributions had been donated to The Caring Fund.

Resolution 90-15, adopted at the KMS Annual Meeting in May 1990, endorsed the medical society's continued commitment to the program. It encouraged the KMS Auxiliary to consider supporting the program, and the auxiliary's contributions to date have paid for 11 participants' coverage. Resolution 90-15 also urged county medical societies to look into the program for possible adoption and exhorted Kansas physicians to support The Caring Program in any ways they can.

If you are interested in learning more about The Caring Program for Children, call Val Braun at KMS, 800-332-0156 or 913-235-2383.

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THE WAY IT WAS

KANSAS MEDICINE, in its effort to draw on the pre-disposable days of the past to keep the present of medical service in perspective, presents the following dissertation gleaned from the December 1914 issue of The Journal of the Kansas Medical Society.

THE DIAPER

The diaper is an essential part of the mystic regalia used in the initiation of new members into the Ancient Order of Sons and Daughters of Adam.

The novice is seized by the Keeper of the Sacred Portal, hastily inspected, with a view of classification, disentangled from his cable-tow, and then passed along to the Custodian of the Precious Secrets, who applies this venerable and indispensable insignia in due form and manner.

The convenience with which this simple, rectangular vestment is applied or removed, and its ingenious adaptability to certain anatomical conformations, will always be a matter of genuine wonderment, and awaken infinite speculation as

to the predicamental consequences that must have ensued down through the generations, if such a providential contrivance had not been devised.

It is necessary for the new member of the Order to wear this emblem of innocence and incapacity until he (or she) shall have attained to that degree of worldly wisdom that entitles him (or her) to wear the habiliments belonging to higher rank.

The diaper is not the only badge worn by the neophyte. There is also a pin of distinctive design and special significance, intimately associated with it. The device pertaining to this pin and motto of this degree is "Safety First."

Indeed, so closely identified are these two elements of the regalia that either one almost invariably suggests the other. Hence, when we see a person in the higher stations of life employing this symbolic pin for some extemporaneous adjustment of the costume or for attachment of some small accessory of the attire, we are prone to become reminiscent, either of some private personal experience, or of some observation, not always of a nature suitable to relate.

To the medical man these observations are multitudinous and variegated, as well as *scentimental*. They lose their allegorical significance to the physician, and become intensely sensuous and practical. He learns to read the cryptograms emblazoned on these squares of cloth with infallible proficiency. Just as the Egyptologist deciphers the hieroglyphs of pyramid or obelisk, so the doctor reads the picture-language and interprets the peculiar tints and tones on these small bits of domestic tapestry. Every little movement depicted there comes to have a meaning all its own, to his trained intelligence.

Strange as it may seem, there is little treasuring of this portion of the infant wardrobe. Shoes, stockings, caps and jackets are often held in sacred keeping against that far-off day when they may be brought forth and submitted to the wondering inspection of proud descendants. But the diaper, most intimate and convincing token of utmost beginnings, is never, no never, on display as an heirloom. This is because man is prone to become artificial and ultra-aesthetic, as the years go by, and utterly ungrateful toward those humble agencies that, in times of direst need, stood between him and the most serious breaches of social conventions.



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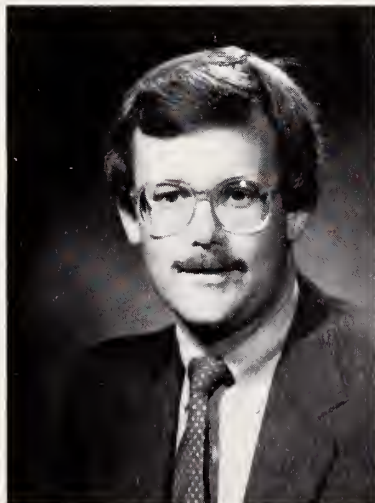
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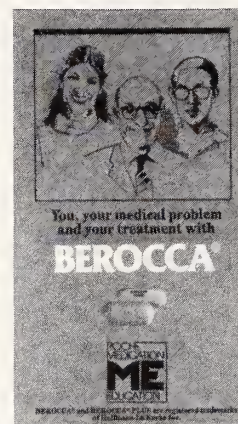
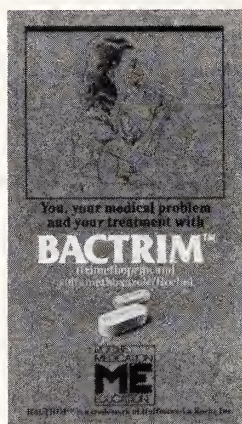


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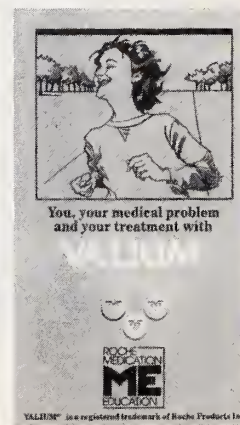
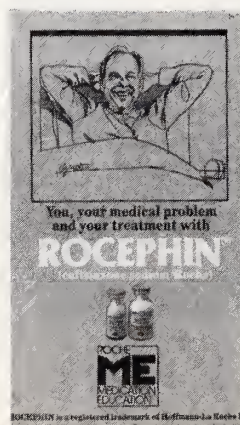
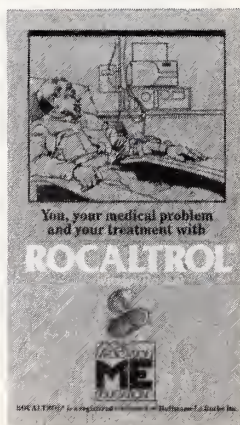
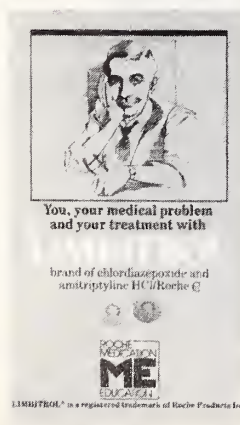
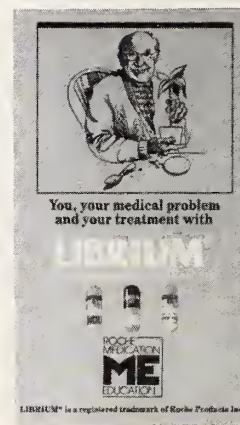
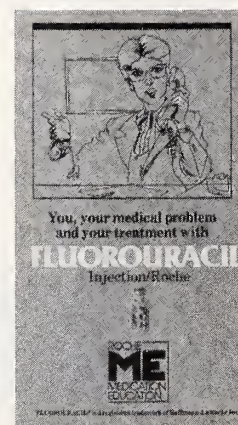
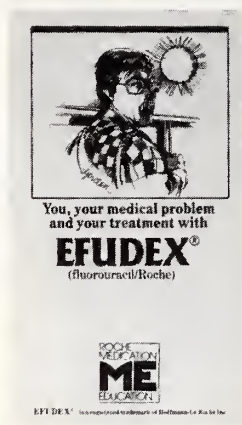
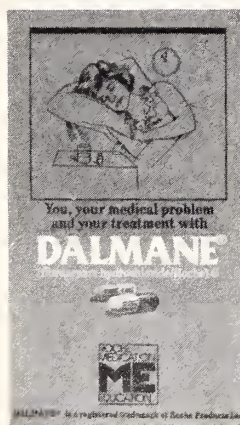


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Benign Breast Disease

PATRICK E. MCGREGOR, M.D., AND THOMAS E. SNYDER, M.D.,* *Kansas City*

Breast pain or the discovery of a breast lump in a woman can create a very anxious situation. The immediate and primary concern of both the patient and her physician is the question of whether or not the mass is malignant. The vast majority of new masses found by patients or physicians are benign. But differentiating benign from malignant breast lesions is not always easy. Widespread incidence, debate of classification and implications of certain lesions make the evaluation of benign breast disease (BBD) a topic with which physicians must be familiar. The following discussion includes the various types of benign breast conditions, the attendant risks of each type, and management options for these ubiquitous conditions.

Incidence

The incidence of benign breast disease has been noted to be as low as 25% and as high as 100% in various studies. The histologic changes that constitute the disease are so widespread that Love et al. questioned whether "fibrocystic disease," the most common benign condition in the breast, should actually be classified as a disease.¹⁶ Sinclair et al. state that "it is both misleading and without predictive value to label as abnormal the breast of 50% of all women."²³ The American Cancer Society now regards the term "fibrocystic disease" unacceptable, and a consensus of U.S. pathologists has proposed replacing it with "fibrocystic changes."⁴ Love feels the term "physiologic nodularity" is more descriptive and closer to fact. The incidence of BBD is not consistently correlated with age. However, there is general agreement that benign breast disease is uncommon before age 20, and more prevalent in women in their 20s, 30s and 40s. Whatever the true incidence, breast lumps and breast pain represent a spectrum of physiologic and/or malignant changes that warrant further evaluation, since one out of 11 women will eventually develop breast cancer.

Clinical Presentation

The two most common complaints of a woman with benign breast disease are pain and tenderness (mastodynia). Patients describe this pain as a dull ache or unpleasant sensation of fullness in the breasts. The pain is usually bilateral and most prominent in the upper outer quadrants. Generally, patients correlate fluctuations in pain and tenderness with their menstrual periods. The pain usually begins one to two weeks prior to the onset of menses and subsides when the menstrual period begins. Between 5 and 8% of patients presenting with breast discomfort have severe and disabling pain.²² Edema in the breast parenchyma, with increase in breast volume of up to 15%, results in pulling and tugging on the breast lobular architecture. This initiates an inflammatory response which is the hypothesized etiology of the pain.

The third most common presenting symptom is that of a palpable, unilateral, tender and firm mass. The site of this mass is again usually in the upper, outer quadrant of the breast. Changes in the lump size and/or nodularity are common during the course of one or more menstrual cycles.

In addition to mastodynia and palpable masses, nipple discharge is frequently seen. This secretion may be spontaneous or may only appear on compression. The discharge may be clear, milky, or straw-colored, but generally is greenish-brown to black in color.

Scanlon defines fibrocystic disease as "a condition in which there are palpable lumps in the breast, usually associated with pain and tenderness, that fluctuate with the menstrual cycle and that become progressively worse until menopause."²⁰

Classification

The number of different classification schemes for benign breast diseases nearly equals the suspected incidence. The classifications used in this paper are those advocated by the College of American Pathologists based on histopathologic characteristics of tissue obtained by breast biopsy.⁴ Almost all breast biopsies will have some elements of fi-

*KUMC-KC

Address correspondence and reprint requests to Dr. Snyder at Department of Gynecology and Obstetrics, KUMC-KC, 39th & Rainbow Boulevard, Kansas City, Kansas 66103.

brocystic change, particularly cyst formation.¹⁰ Traditionally, fibrocystic disease has been understood to include the histopathological entities of macrocysts, microcysts, adenosis, apocrine change, fibrosis, fibroadenomas and ductal hyperplasia. The histologic type present in most biopsies is rarely single, but usually a mixture of these benign morphologic changes.

Non-Proliferative Fibrocystic Change

This group includes mild ductal or lobular hyperplasia, cysts, duct ectasia, fibrosis, inflammation, apocrine or squamous metaplasia and fibroadenoma. Cysts are the most common cause of a breast lump or mass.

Cysts result from dilation of a terminal lobule when no epithelial hyperplasia is present. With fluid collection, the cystic mass becomes palpable. Cysts are divided into two categories, micro and macro. Microcysts are non-palpable, asymptomatic, less than one millimeter in size and considered to be a normal involutional phenomenon in many women. Macrocysts are usually greater than three millimeters and are formed by mechanical obstruction of fluid outflow. With the epithelial lining unable to absorb fluid at the accumulating rate, the result is a "tension" cyst, which may become a palpable lesion.

Mammary duct ectasia can be construed as a variant of pure cystic disease. It is characterized by dilation and stasis of ductal debris and fluid in the terminal collecting ducts with an associated inflammatory reaction, which occurs in the nipple and as a subareolar process. The inflammatory response is often associated with a palpable one-to three-centimeter periareolar mass. A thick, sticky nipple discharge is also a common presenting symptom. The mass, pain and inflammation appear to be more common in younger, premenopausal women; nipple discharge predominates in perimenopausal women; and nipple retraction secondary to periductal fibrosis is more often noted in the postmenopausal group.¹¹

Fibroadenomas are the most common cause of dominant breast masses in women under the age of 25, and are rarely seen in postmenopausal women unless they are taking supplemental estrogen. Fibroadenomas also tend to appear more frequently in black women. The etiology is unclear, but a relationship to hormones has been suggested. These lesions are palpable as firm, rubbery, well demarcated, mobile masses. Most are painless and do not vary in size with changes in the menstrual cycle. In the majority of cases, fi-

broadenomas are solitary and slow growing. During pregnancy, fibroadenomas may grow in response to hormonal stimulation and may regress post-partum. Following menopause, involution results in calcification of the lesion.

Both ductal and lobular epithelium can undergo a metaplastic transformation to apocrine epithelium. This is known as apocrine metaplasia.

Mild hyperplastic changes can take place in the lobules, forming multiplication of the acini known as adenosis. It typically affects all epithelial elements within the lobule.

Since these histologic entities are not associated with any increase in relative risk of developing invasive carcinoma, the College of American Pathologists groups them together.⁴ This relative risk was calculated by comparison to age-matched controls who had never undergone a breast biopsy. However, Carter et al. assigned a relative risk value of 1.7 to women with fibroadenoma and an age-adjusted breast cancer incidence rate of 334.3, compared to 206.5 for normal subjects.⁵ Also, Hendler states that because apocrine metaplasia represents a proliferative change in epithelium, it has been shown to be associated with a minimally increased risk of breast cancer.¹⁵

Proliferative Fibrocystic Change

This class consists of moderate or marked hyperplasia without atypia in ducts or lobules and includes sclerosing adenosis, epitheliosis and papillomatosis.

Sclerosing adenosis is adenosis as mentioned above with a stromal proliferation. This reactive fibrosis often creates a palpable nodule. Sclerosing adenosis is more common in the late menopausal years.

Epitheliosis refers to epithelial hyperplasia resulting in tongue-like projections within ductal structures. These projections do not have a fibrovascular core. Epitheliosis is a truly proliferative lesion and lies in a continuum from the obviously benign to lesions often impossible to discriminate from malignant.

Intraductal papillomas are relatively uncommon, but constitute a primary cause of non-physiologic nipple discharge and bleeding. Though generally found during the menopausal years, they may occur in women of any age. They are formed by a villous projection of a fibrovascular core covered by an epithelial layer, and usually arise in larger ducts. Approximately 50% of these papillomas will be palpable.¹⁵ A distinction must be made between solitary and multiple intraductal



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papillomas. Multiple papillomas tend to occur in premenopausal women and are more likely to present as a mass rather than as nipple discharge. Solitary papillomas are not associated with an increased risk of breast cancer, whereas multiple papillomas have been linked to a significant risk (20 to 30%, or four times) of developing breast cancer.¹⁵

Proliferative lesions without atypia have a two-fold relative risk increase for development of invasive carcinoma, according to the College of American Pathologists.⁴ Hendler reports a cancer incidence of 6.4/1,000 for patients with sclerosing adenosis, and 7.5/1,000 for those with epitheliosis, representing more than a mild increase.¹⁵

Atypical Hyperplasia

This category represents any of the previously mentioned ductal or lobular hyperplastic lesions with noted histologic atypia mimicking carcinoma-in-situ. Patients with these lesions have a five-fold relative risk for developing invasive carcinoma.⁴

The one constant throughout this classification scheme, and the many others reviewed, was that the presence and degree of atypia in biopsied lesions was directly related to the relative risk of developing breast cancer.

Etiology

The prevalence of benign breast disease has elicited much speculation and controversy about possible causative agents. The relationship and physiologic response of many of these lesions to hormonal manipulation have led to consideration of hormonal effect as the most plausible etiologic theory. Pastides et al. showed a positive relationship of estrogen replacement therapy in postmenopausal women to the development of fibrocystic breast disease. They also found that age-adjusted ratios of fibrocystic disease increase with duration of estrogen replacement therapy. Women using estrogen replacement therapy for three or more years were nearly three times as likely to have fibrocystic breast disease as women who never received such therapy.¹⁷ This increased risk was found only in those women who underwent natural menopause, as opposed to surgical menopause.

Other etiologic factors such as hyperprolactinemia, hypothyroidism and caffeinism have produced equivocal effects. More recent data indicate that breast tissue synthesizes and is responsive to

TABLE 1
GUIDELINES FOR SCREENING MAMMOGRAPHY

<i>Age</i>	<i>Frequency</i>
35-39	Baseline
40-49	Biannual (yearly in high-risk patients)
50 +	Yearly

many peptide growth factors as well as steroid hormones.¹⁵

Diagnosis

Breast examination remains an excellent screening and primary detection tool for palpable masses. Whether this is a self-examination or a routine one by a physician, it must be performed in a thorough and systematic manner. Small lesions are often not detected, and changes observed on physical examination do not allow one to predict the risk of developing malignancy. Therefore, examination of the breast can only be viewed as part of the workup to define whether benign or malignant breast disease is present.

Ultrasound in sonomammography is useful for distinguishing solid from cystic breast masses, as well as in localizing lesions for possible needle aspiration. Ellerhorst-Ryan et al. contend that ultrasound may be more effective in evaluating lesions in younger women with more dense breast tissue than x-ray mammography. Ultrasound's true utility appears to be in further defining a lesion which has been detected by another modality.

Mammography is an important screening tool in women over 50 and is indicated in any woman over 35 years of age with breast complaints or abnormalities. The overall diagnostic accuracy of mammography alone is 85%.¹¹ Mammographic examination has the ability to define the parenchymal pattern, as well as to detect mass lesions and calcification. The American Cancer Society guidelines for screening mammography should be followed (Table 1).

In women with a palpable discrete breast mass, fine-needle aspiration cytology (FNAC) is extremely useful. The technique is straightforward and can be done in the office. Among other advantages: 1) results are quickly obtained, 2) it is inexpensive, 3) it may be both diagnostic and therapeutic, and 4) there is little associated morbidity. An accuracy of 98 to 99% in diagnosing malignant lesions has been reported.¹⁹ Both fluid and tissue can be aspirated by FNAC. There has been disagreement about disposition of obtained

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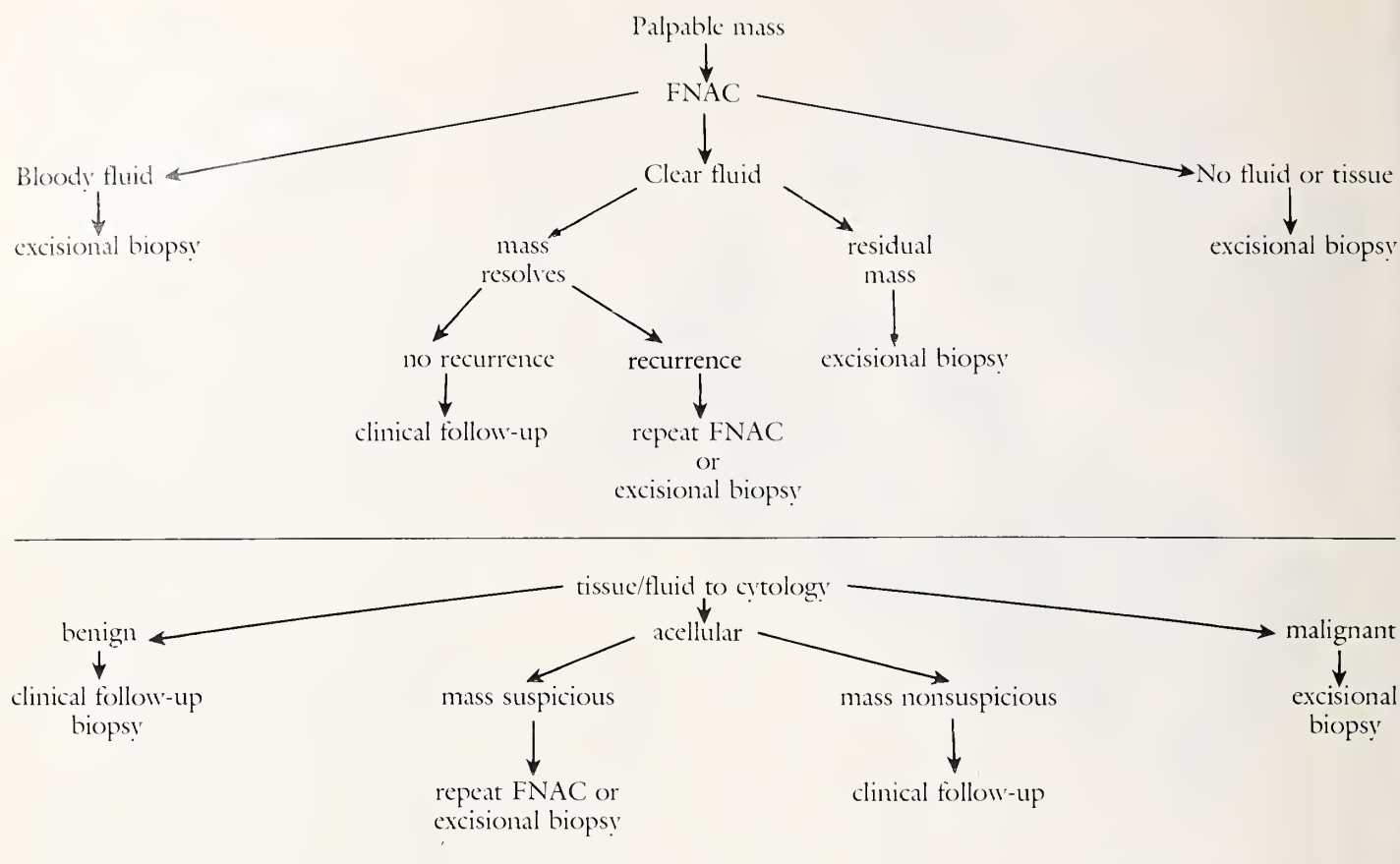


Figure 1. Results and further treatment after aspiration.

fluid. Some clinicians advocate discarding it if it is absolutely clear and free of visible debris, since the chance of finding cytologic characteristics of significance is minimal. However, Drukker et al. believe that all specimens should be submitted for cytologic evaluation. A flow chart for results and further treatment after aspiration is presented in Figure 1. FNAC reported in the clinic allows immediate diagnosis of a breast lump and reduces the number of open biopsies in benign breast disease.⁸

With the use of FNAC, the overall excision rate for discrete solid lumps was reduced from 83% to 41%, and the excision rate in patients with benign disease was reduced from 74% to 23%.⁸ Sainsbury recommends that patients under 35 years of age with clinically and cytologically benign breast lumps be offered the option of non-excision with the reasonable expectation of resolution of their lesion. This recommendation was given following the finding that 49% of discrete benign breast lumps can be expected to resolve with time.¹⁹

Excisional biopsy is the definitive management if indicated initially, or if FNAC is not adequate. There are no sampling errors if the mass is excised.

Of course, open biopsy does involve more risk for the patient.

Studies by van Dam have shown that multimodality evaluation of breast masses is diagnostically superior to single-modality evaluation. He reported that multimodality work-up increased the sensitivity to 97%, and that physical exam and ultrasound of a palpable breast mass form the optimal preoperative test combination. In addition, mammography is necessary to detect sub-clinical cancer and to augment the reliability of the diagnosis.²⁴

Treatment

Surgical management of palpable lesions is outlined above, but non-palpable symptomatic lesions and multiple small lesions may be treated successfully with non-surgical means. Medical management has also been employed in these situations. Drugs such as estrogen, danazol, tamoxifen and bromocriptine have been shown to be effective in reducing proliferative changes on mammography and in reducing the incidence of biopsies.

There are no studies with biopsy material demonstrating that these agents have any efficacy in

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the treatment of proliferative breast disease with atypia, nor that they reduce the risk of developing cancer. Therefore, they can only be considered a means to treat symptoms and reduce the number of surgical procedures.

Hormonal intervention has shown the greatest impact in reduction of symptoms and nodularity. Breast tissue is sensitive to estrogen and thus is the basis for most of the hormonal therapy. The use of a low-dose estrogen and relatively high-dose progesterone oral contraceptive has been shown to produce a 70 to 90% improvement in symptoms and significantly reduce the breast biopsy rate. The recommended length of trial is at least one year, and maximal benefit may be reached at two years.¹⁵ The length of protection and duration of decreased symptoms following oral contraceptive therapy are still debatable. It must be realized that the oral contraceptives used in these studies contained significantly higher amounts of sex steroid hormones than the present standard oral contraceptives.

Danazol, a synthetic derivative of norethisterone, and an antiestrogenic compound, has been effective in the management of symptoms of fibrocystic change. The efficacy of danazol may be as high as 90%, and the response rate is much quicker than with oral contraceptives, being observed within four months.¹⁵ Danazol works via a physiologic mechanism by decreasing levels of follicle-stimulating hormone and luteinizing hormone, with concomitant reduction in estradiol production and breast stimulation.

Doses of 200 to 400 milligrams per day seemed to be most effective. However, the side effects are also dose-related. The main problems with therapy are amenorrhea, weight gain, hirsutism and acne. The relapse rate following cessation of danazol therapy has been reported as greater than 50% within one year.¹⁵

Tamoxifen, a partial estrogen agonist, has also been investigated and shown to have a slightly lower response rate of approximately 70%.¹⁵ The onset of symptom relief with tamoxifen is similar to that of danazol, and the side effects are much less dramatic. The only significant known side effects are the development of menstrual irregularities and menopausal symptoms. Symptom control and benefit were reported for at least two months following completion of treatment.⁹

Bromocriptine also seems to effectively reverse proliferative changes by mammography. Complete or nearly complete resolution of symptoms was obtained in 75% of patients.⁹ These results

do not correlate with serum prolactin concentrations.¹⁵ Despite this reported success, the side effects of bromocriptine therapy, including nausea, vomiting and headache in 50 to 60% of patients, make its use unacceptable for those patients.

Dietary alterations, particularly the reduction of methylxanthines, received much attention as a possible treatment of fibrocystic breast disease in 1974, following the report of Minton. Since that time, however, Minton's results have not been reproduced, and the effect of caffeine on fibrocystic breast disease is equivocal. Still, the fact that withdrawal of caffeine has only beneficial side-effects and is inexpensive, makes a trial of decreasing or eliminating intake of caffeine a reasonable choice.

Vitamin therapy in treatment of breast disease has met with varied success. Results of trials with vitamin E have not shown significant differences between treatment and control groups with respect to decreasing proliferative breast disease. Several reports have shown recent success with short courses of vitamin A therapy. These results require further study to determine the role of vitamin A in the management of fibrocystic symptoms.

Conclusion

The vast number of women affected by benign breast disease makes this condition one which physicians will often encounter. Fibrocystic changes appear to fall into a spectrum that ranges from normal to pathologic, and where the delineation between the two lies is still unknown. It is evident and accepted by most investigators that the risk of developing invasive carcinoma is not uniformly distributed across all types of benign breast diseases, and that the risk is proportional to the degree of histologic atypia. This fact highlights the need for cytologic or histologic diagnosis of all discrete lesions. Tissue diagnosis will define whether surgical or non-surgical management is indicated. Conservative management of biopsy-proven and clinically benign lesions is reasonable with adequate follow-up. But further clinical trials investigating medical management of fibrocystic changes are needed.

REFERENCES

A list of references may be obtained from the authors.

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PRESIDENT'S MESSAGE

(Continued from page 90.)

resource is the Kansas Medical Society. Today it commands the highest respect among professional organizations in the state. This is best epitomized by the statement made by a prominent Kansas legislator before a national audience: "When I need to know something about . . . medicine in Kansas, I contact the Kansas Medical Society." Such respect is not easily won and requires constant effort to maintain. Through the commitment of each of us, by our continued membership, our personal involvement, our willingness to devote time and energy to addressing the issues we face, we have the organizational structure in place to effect a successful outcome. I hope to hear from each of you soon at our annual meeting, if not in person, then through your district councilors and delegates. We can be thankful that through our continuing efforts in the past and present, the Kansas Medical Society is a strong and clearly heard voice for Kansas medicine.

Joseph E. Grech, M.D.

MEDICINA ET LEX

(Continued from page 92.)

acts provided that the intermediaries may examine medical records in connection with the Medicare audit. Medicaid regulations permit access by HHS upon request.

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It has been the practice of physicians and hospitals to provide medical records to third-party payers based upon medical authorizations. Generally, these are obtained at the time of hospitalization by the admitting office, or at the time the claim is made to the insurance carrier.

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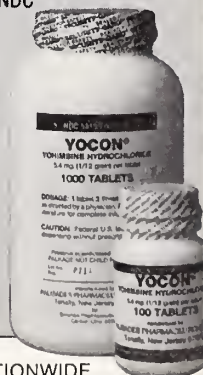
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Experience has shown that the organization seeking such records pays little attention to the concerns that physicians may have regarding their duties of confidentiality. Occasionally, they request medical records for spouses and children who are adults, even though these individuals have not consented to the release of the information. Certainly, scenarios may be conceived of in which the patient may violently object to release of the information to any third party, such as information pertaining to pregnancy, abortion, AIDS or similar circumstances.

It appears that a patient may contractually agree to release medical information, even prior to the dates such service is provided. It is likely that a court would uphold the authorizations originally given to the HMO as valid.

It is conceivable that a patient receiving treatment because of a dependency relationship may claim that the contributor/insured did not have authority to authorize the release of medical records. The routine release of records, based upon requests of third-party payers, which are frequently handled by insurance clerks in the physician's office, can lead to the possibility of potentially embarrassing information being released. Certainly an argument can be devised indicating that this release is not authorized, and the party requesting the information, as well as the physician, have violated the patient's rights. Given the possibility of litigation, a physician should request an authorization in instances where particularly sensitive information is requested concerning a patient who is not a party to the HMO contract.

CARDIOLOGY NOTES

(Continued from page 114.)

peripheral embolism, are estimated from the literature and range from less than 2% for conditions such as atrial fibrillation in young persons with no structural heart disease to more than 6% for unstable angina, recent balloon dilatation (PTCA) or coronary bypass surgery (CABG).

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The table summarizes the risk classification and recommended therapy for a number of cardiac conditions in sufficient detail to begin therapy. The original article provides extensive bibliographic support, and exceptions are discussed in detail.

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OCCUPATIONAL MEDICINE OPPORTUNITY. Opportunities available for permanent and permanent part-time positions in Occupational Medicine in the Kansas City metropolitan area. Responsibilities include pre-employment screenings, periodic evaluations and evaluation and treatment of work-related injuries. Previous experience in occupational medicine is desirable; however, training in general surgery, orthopedic surgery, internal medicine or family practice may be acceptable. Excellent compensation and flexible hours. If you are interested in these positions, please contact Ms. Judi Iggens, Professional Relations, 3101 Broadway, Ste. 1000, Kansas City, Missouri 64111; or call 816-561-2105.

Anticoagulants in Heart Disease

DONALD L. VINE, M.D.,* *Wichita*

The risk of embolization and the pathogenesis of clot formation are used by Stein and colleagues from the Mount Sinai Medical Center in New York to develop an approach to anticoagulant therapy that is straightforward and easy to apply in many clinical settings.¹

ditions such as unstable angina and soon after thrombolytic therapy for acute myocardial infarction (MI), are treated with heparin and antiplatelet agents such as aspirin, or both.

Intracavitary thrombosis associated with fibrin deposition in dilated cardiomyopathy or acute an-

TABLE 1
ANTICOAGULANT THERAPY BASED UPON ESTIMATED RISK OF
THROMBOSIS OR THROMBOEMBOLISM

High (> 6% per year)	
Unstable angina Acute myocardial infarction Early after thrombolytic therapy, PTCA or CABG	Platelet inhibitor; additional heparin during acute setting (PTT 1.5-2.0 × control)
Atrial fibrillation (associated with prior embolus or mitral stenosis)	Anticoagulant (PT 1.5-2.0 × control)
Mechanical prosthesis—older models — or mechanical prosthesis plus prior embolism	Anticoagulant (PT 1.5-2.0 × control) plus platelet inhibitor
Medium (2-6% per year)	
Chronic stable angina Post myocardial infarction Post CABG	Platelet inhibitor; anticoagulant risks additional bleeding and may not be superior to aspirin
Atrial fibrillation—other heart disease	Anticoagulant (PT 1.3-1.5 × control)
Early after anterior MI Dilated cardiomyopathy	Anticoagulant (PT 1.3-1.5 × control)
Newer mechanical prostheses or bioprostheses plus atrial fibrillation	Anticoagulant (PT 1.5-2.0 × control [1.3-1.5 for bioprostheses plus atrial fibrillation])
Low (< 2% per year)	
Primary prevention of cardiovascular disease	Platelet inhibitor for patients at high risk for coronary disease
Idiopathic atrial fibrillation Chronic LV aneurysm Bioprostheses—sinus rhythm	Usually none

Pathogenesis and Treatment

The pathogenesis is related to the location of the abnormality: the arteries, cardiac chambers or prosthetic valves.

Vascular injury, activation of the clotting system and intraluminal thrombosis, seen in con-

terior myocardial infarction with extensive left ventricular wall motion abnormality is treated with coumadin anticoagulants.

Thromboembolic complications associated with prosthetic heart valves are best treated with coumadin anticoagulants.

Risks

The annual risks, such as thrombotic occlusion or

(Continued on page 112.)

*Associate Professor, Department of Medicine, University of Kansas School of Medicine-Wichita

Address correspondence to Dr. Vine, Department of Medicine, UKSM-W, 1010 N. Kansas, Wichita, KS 67214.

Notes & Quotes

NEWS FOR AND ABOUT KMS MEMBERS

APRIL 1991

License Renewals to be Mailed in May

During the first week of May, the Board of Healing Arts will mail license renewals to all currently licensed Kansas physicians. The renewals will be sent to the mailing address most recently reported to the Board. Physicians who have since moved should immediately notify the Board in writing. In addition to active status, the following licenses are offered and may be selected as current needs dictate:

Inactive. For licensees not residing in Kansas, and not rendering any professional services in Kansas. Malpractice insurance coverage and CME hours need not be maintained.

Federal Active. For licensees who are in the military service of the United States and/or employed by the federal government and who must maintain a current, active Kansas license. No private practice outside federal employment is allowed in the State of Kansas. CME is required (see the License Status Form for details).

Exempt. For licensees who do administrative work, provide gratuitous services or services as a charitable health care provider, or prescribe only to themselves, their immediate family and friends at no charge, and who do not maintain a regular Kansas practice or practice location. Malpractice insurance coverage and CME are not required. See the License Status Form accompanying the renewal form for details.

Licensees who have an exempt, inactive or federal active status with the Board must complete a License Status Form, which will be included with the renewal. If you desire conversion to exempt status, you should request an exempt license application form from the Board.

To continue to be licensed in Kansas, you must fully complete the renewal application, remit the renewal fee and provide all required documentation. If you actively practice in Kansas, you must provide evidence of professional liability insurance. Also, the date in the upper right corner of your mailing label indicates the year you must submit evidence of satisfactory completion of continuing education, as explained in the renewal notice. (If "91" appears on the label, the continuing education form must be completed for renewal this year.) Renewals which do not meet these requirements will be rejected and returned without renewal until the requirements are met.

The fee for renewal prior to June 30, 1991 is \$150. For renewals mailed after June 30, the fee will be \$200. Renewals mailed after July 30 will be cancelled, and the license will have to be reinstated. Continued practice in Kansas after cancellation of a license will subject you to disciplinary action by the Board and will also jeopardize coverage by your professional liability insurance carrier and your ability to receive payments from your patients' health insurance carriers.

Please note that the address for the Board of Healing Arts is 235 S. Topeka Boulevard, Topeka, Kansas 66603.

AASP Offers Seminars on Retirement Planning

The American Association of Senior Physicians is offering retirement seminars at various locations around the country. "Achieving a Successful Medical Retirement," a three-day seminar for physician couples, will be presented May 17-19, July 12-14, September 27-29 and November 22-24, 1991, in San Antonio, Denver, Williamsburg (Virginia) and Nashville, respectively. The one-and-a-half-day seminar "Thinking of Your Future Today," designed for the fully retired physician couple, will be given October 19-20, 1991, in Chicago.

To register for these seminars, call Jill Rubiner at AASP headquarters in Chicago, 312-464-2461.

Enter the ASCP/Nikon Medical Photography Competition

This competition, sponsored jointly by the American Society of Clinical Pathologists and Nikon, encourages and recognizes excellence in medical photography. All entries are judged on scientific merit, content, composition, quality of image and originality. Up to three entries may be submitted in each of three categories: gross photography, light microscopy and electron microscopy. Cash prizes will be awarded, and the winning entries will be exhibited. Full details and entry forms are available from ASCP, Attn: Medical Photography Competition, 2100 West Harrison Street, Chicago, IL 60612; or by calling 800-621-4142. The deadline for submission is June 1, 1991.

May Observances Feature Nurses, Medical Transcriptionists and the Elderly

The contributions of nurses and medical transcriptionists to the health care team are recognized during the month of May. National Nurses Week is May 6-12 (concluding, appropriately, on Florence Nightingale's birthday). National Medical Transcriptionist Week follows, on May 13-19.

The entire month of May is Older Americans Month, as well as National Sight-Saving Month, so it is appropriate to remind physicians of the Helpline of the National Eye Care Project, from which a referral may be obtained for a needy elderly patient to see a volunteer ophthalmologist. The Helpline number is 800-222-3937.

Older Americans Month would also be a fitting time to encourage elderly patients to put all their medicines (prescription and non-prescription) in a bag and bring them in for a "brown-bag review." This is an effective technique to reduce the risk of avoidable adverse drug reactions, discover duplicate or outdated medicines, review instructions for use, advise about possible side effects and solve compliance problems.

Don't Go Near the Water!

As National Alcohol Awareness Month draws to a close, it seems prudent to warn the unsuspecting of another potentially intoxicating liquid: water. A recent account in JAMA reported the case of a flight attendant whose speech became slurred and whose thinking became hazy after she drank three liters of water in order to produce a sample for a urine drug test.

Seven other cases of water intoxication--one fatal--have been reported to date. When it occurs, the brain cells become waterlogged, and the body's minerals are diluted. No wonder W. C. Fields recoiled from that fatal glass of water!

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Journals

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Hemobilia from a Ruptured
Hepatic Artery Aneurysm



KANSAS MEDICINE

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**ABOUT OUR LOGO**

In January 1935, a new logo appeared on the cover of KANSAS MEDICINE for the first time. This device represents two stethoscopes: the original monaural type as used by Laënnec, and the modern binaural variety. The logo was designed expressly for KANSAS MEDICINE by renowned graphic designer Bradbury Thompson, a native of Topeka and friend of two former editors of the journal, Dr. W.M. Mills and Dr. Lucien Pyle. As another former editor, Dr. Orville R. Clark, wrote in January 1955, the logo "has become as much a part of the journal as any of the features on the inside and is something which is ours alone."

Among the rites of spring as celebrated in Kansas, none is more awesome than the burning of the prairies. At one time, it was not an intentional occurrence, and for the early settlers it could be a fearsome threat. Joanna Stratton, in her account of prairie life as recorded by the women of the day, quotes one: "In those days of endless sweep of prairies when the tall grass became dry from premature drying from drought or early frost, it was a signal for close vigilance. . . . A light against the sky told of a prairie fire in that direction. . . . Excitement was keen when fires were seen, and the men always took wet sacks and hastened to fight the flames, sometimes working for hours before it was under control."

From such devastating events, however, came the knowledge that the burning of the prairies in the spring was beneficial to the control of unwanted growth and promotion of the tall-grass renewal. The age-old threat of prairie fire from lightning or human-generated accidents is not forgotten, but an ecologically justified ceremony has become a part of springtime in much of the tall-grass area. The vision of the tell-tale light in the distance has given way to a well-planned and controlled event. Men with wet sacks may still be at the ready, but so are township fire departments; the haphazard threat has been replaced by a planned and coordinated event.

That is the story told in Jim Hamil's painting of a typical prairie burn-off.

**ATTENTION,
KMS MEMBERS!**

Please take a moment to check your listing in the 1990 *KMS Membership Directory*. Is everything in it still current? If not, please notify Ramona Perez, Membership Secretary, at 800-332-0156 or 913-235-2383.

New directories will be mailed in August.

A Dog's Life

It was a simple matter of coincidence. The morning paper carried a brief story telling of animal rights activists seeking to ban animal dissection in schools, and the "Pulse" section of *JAMA* carried the commentary of a young medical student regarding his group's physiology lab exercise on a dog. The news story reported the usual complaints of the activists and the standard response of the AMA maintaining the value of introducing school children to the intricacies of animal structure and implied function. The "Pulse" article, on the other hand, reported in some depth the student's reaction to "operating" on a dog to observe various physiological phenomena. Such exercises are, of course, well known to medical students as a means of experiencing the surgical process, as well as analyzing and recording observations on the animal's physiology. The final result is, it will be recalled, the demise of the dog.



The interesting aspect of the *JAMA* article was that after an almost glowing report of the experience, the writer came to the conclusion that it wasn't a necessary exercise, after all, and certainly did not warrant the sacrifice of the dog. The lessons learned could have been obtained otherwise with comparable benefits and without the taking of an animal's life. The change of heart was apparently brought on by a new awareness of sensitivity for the dog's life that had been submerged by the dictates of the protocol prior to the revelation.

On the face of it, one might assume the score was now Activists 1, Animal Research 0. The student may be on his way to becoming a card-carrying activist, but he will, if his principles so dictate, find it difficult to turn his back on all medical functions based upon the sacrifice of various animals along the way. He may well find himself debating between the human patient who needs a procedure or medication derived from animal experimentation and this complicating sensitivity. He will have to develop a perspective which provides for the necessary appreciation for animals or others involved in the process. We have no intention of derogating or patronizing him. We suggest, however, that he did learn something from

the experience (even if it was not just canine physiology), and therefore a justification for the experience was proved.

We doubt that he would see it in this paradoxical light, but it seems he will go on to be one of those physicians with a personal sense of compassion that rejects the concept that animal experimentation is an absolute necessity. Arrival at this attitude is, of course, a state of mind made possible by the past successes of that very activity. It is a luxury resulting not just from the survival of more humans than ever before; indeed, a cynic would argue that most of our troubles are due to that very thing. (So far the animal activists haven't promoted the discontinuance of such experimentation as an indirect method of solving the world population crisis.) But the fact is that those same activists, in their misanthropic zeal to defend those they consider defenseless, do seem willing to obstruct the very efforts that provide healthier humans to share the world with those other animals who require their protection.

There is a definite value to the animal activists' approach — beyond the possible survival of some of the links in the biological chain they celebrate. It does stimulate investigators to seek new methods for their investigating and, though these may seem an immediate impediment to their plans, new avenues of approach may be devised which may be, after all, to their benefit. Conscientious, qualified investigators are well aware that respectful handling of their subjects is not only humane but essential to the quality of their work. Those "activists" resorting to violence (which must surely be the ultimate perversion of the activists' intent) are human aberrations who should surely be disavowed by their more temperate colleagues — but so should those investigators who fail to apply their discipline to the care of their charges.

Our student does arrive at one conclusion that bears out that point. He came to think of the dog as a "subject," not an "object." It is a fine point but a commendable and, in fact, essential one in responsible research. And he can comfort himself that the dog probably came from a pound from which it would certainly have reached the same (but perhaps less valuable) end. Perhaps our student should express his sensitivity by working to control the stray animal population. D.E.G.

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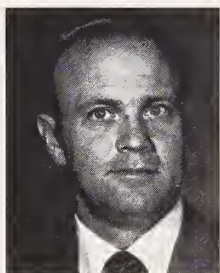
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On the Privileges and Responsibilities of Being a Physician

One early morning not long ago, I had the privilege of assisting a young couple with the delivery of their first-born child. The wonders of conception, embryology, labor and delivery were still in my heart as I walked down the hall to enter a room where I sat to hold the hand of an octogenarian and comfort her husband as she peacefully and quietly went to be with her Lord. As physicians, we have a unique opportunity to make a difference in the lives and also the deaths of our patients, usually to be appreciated and respected for our opinions and efforts and, at the same time, to be handsomely paid. There is nothing I would rather do than serve in my role as a physician, and I am grateful that we were given the academic abilities, the perseverance and the educational opportunities to become medical doctors.



As physicians, we are held to a high standard of service to our fellow man. At a recent AMA Leadership Conference, Supreme Court Justice Warren Berger reminded us that we are professionals, not tradesmen or businessmen. Justice Berger encouraged us to engage in constructive

criticism of our individual and collective weaknesses, if we truly respect and love our profession. I have been in the past, and will probably be at times in the future, critical of myself, some of our medical colleagues, medical education and the American health insurance industry. I am critical of myself not because of what I don't know, but because of those times when I fail to show concern and compassion. I am critical of colleagues who seem to look at a patient encounter as a business opportunity rather than as a chance to provide care. I am critical of medical education and a health insurance industry which concentrate their resources on the treatment of diseased organ systems, rather than on the care of patients.

We are told that our country will spend \$700 billion on health care this year. Although we could and maybe should spend even more than that, I would have to agree with the 35 million uninsured and millions of others who feel that many of our health care dollars are poorly spent. Our American heritage of debate, compromise and consensus is nationally at work in regard to health care reform. There is no doubt but that the pendulum is already swinging toward a significant change in the American health care system. Current AMA leadership is committed to helping develop the necessary modifications and adjustments needed to provide adequate health care for all Americans, with fair and equitable reimbursement for those who provide it. We must realize that whatever the total price tag, there will be a finite number of dollars available for health care. Whether we are physicians, hospitals, patients or suppliers of pharmaceuticals or health care products, if we take more from the system than we deserve, then somebody, somewhere, will not receive what they need.

Despite the frustrations and challenges facing American medicine today, I am happy to be a physician and proud to have the opportunity to serve you as President of the Kansas Medical Society. Your input will be welcome as I continue to share my observations and concerns through this monthly "President's Message" column.

Larry Anderson MD

PROCEEDINGS

of the KMS House of Delegates, including minutes, adopted resolutions and council district reports, will be published in the June issue of KANSAS MEDICINE.

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Patients' Litigation and the Physician's Duty of Confidentiality

WAYNE T. STRATTON, J.D.,* Topeka

Last month's "Medicina et Lex" column discussed the physician's duty to maintain the confidences of a patient within the context of the release of records to a third-party payer. As was stated there, at common law there is no physician-patient privilege. Through legislation, Kansas has adopted a provision which precludes a physician from disclosing confidential communications between the physician and the patient.



An issue which has arisen with frequency in recent years is whether the attorney defending a personal injury action may interview the plaintiff's physician without obtaining a subpoena or an authorization. Attorneys representing these plaintiffs naturally object to such interviews and seek to limit the terms of medical authorizations, threaten litigation or seek court orders prohibiting such *ex parte* (one-side-only) communications. As was mentioned last month, courts confronted with this issue have reached diverse conclusions.

The Missouri Supreme Court held that the risk of obtaining irrelevant, privileged medical information outweighed whatever benefit the informal accumulation added to the progression of the litigation, and banned the *ex parte* communications.

Other courts have found that the duty of confidentiality continues, even though the privilege is waived. They have indicated that the physician risks a tort action for failing to respect the confidences of the patient.

*KMS Legal Counsel.

Comments appearing herein are not intended as a substitute for legal analysis or advice. Answers to legal questions depend largely upon the particular facts of a case. The reader is urged to consult an attorney for answers to specific legal questions.

These comments do not necessarily represent the views of KANSAS MEDICINE, or the Kansas Medical Society. For further information, contact Mr. Stratton, 515 S. Kansas, Topeka, KS 66603, 1-800-332-0248.

My patient is suing someone. May I discuss his treatment with the other party's attorney?

In Kansas, the basis for the defense counsel's claim of the propriety of such interviews is found in K.S.A. 60-427(d), which provides:

(d) There is no privilege under this section in an action in which the condition of the patient is an element or factor of the claim or defense of the patient or of any party claiming through or under the patient or claiming as a beneficiary of the patient through a contract to which the patient is or was a party.

Recently, a United States magistrate had occasion to review the issue in light of the Kansas statute. In a decision which has now been affirmed by the district judge, *Bryant v. Hilst*, the court made the following findings and observations:

- Whether the physician-patient relationship is one of a confidential nature is undisputed. The issue is whether a litigant-patient, having put his medical condition in issue, may preclude the adverse party from *ex-parte* communications with his health care providers who are potential fact witnesses in the case.
- While a privilege is afforded under K.S.A. 60-427(b), it is removed under K.S.A. 60-427(d). It simply does not exist.
- It is the plaintiff who has placed his medical condition in issue in the case. Since there is no privilege the health care providers are fact witnesses. It would be inappropriate for the plaintiff to have control over the witnesses

(Continued on page 133.)

Tell us where it hurts.

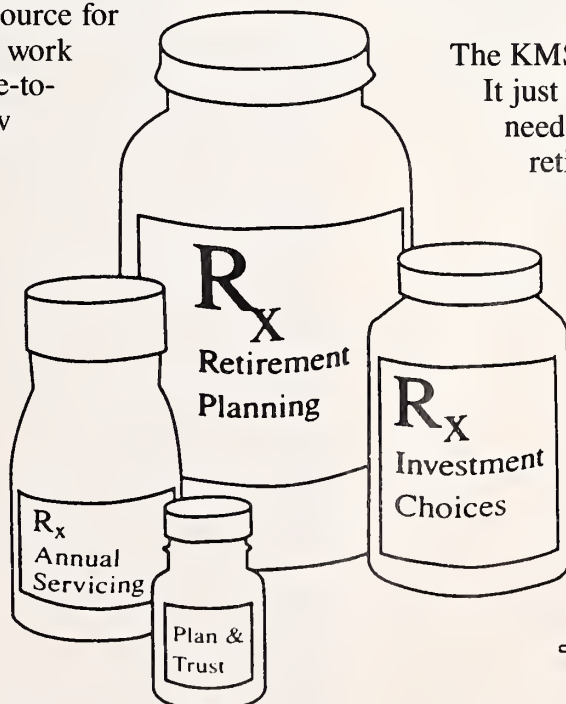
Retirement planning shouldn't be painful . . . but if you're like most physicians, treating your own financial symptoms can be difficult and time-consuming. Knowing your options and opportunities for retirement . . . and then choosing the right plan and funding vehicles are never easy. *And now changes in the tax law require that every existing retirement plan be updated to ensure its continued tax-qualified status.* The wrong choice can really hurt your future.

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THE WAY IT WAS

(From the June, 1907 issue of the Journal of the Kansas Medical Society, we offer what may be the first instance of a chemical peel in Kansas):

POWDER BURN OF THE FACE

By E. Kuder, M.D., Coffeyville, Kan.

About a year ago, I was called in a hurry to relieve the awful suffering of Carl Rucker, of this city, 10 years old, who, when playing with the other boys, exploded about two ounces of coarse black powder in a little earth mound, and not being quick enough to turn away got the most of the discharge in his face; even the conjunctiva of both eyes were blackened, and from the burn and subsequent inflammation shut tight; one of the ears also got burned very badly.

To extract the powder from the skin, I have in years gone by, applied a thick layer of castile soap made into a sort of dough, and as I had to deal here with the inflammation and pain beside, I

scraped a cake of shaving soap, mixed it thoroughly with antiphlogistine, and applied it about one half inch thick all over the face and ears, leaving a hole for eyes, nostrils and mouth. About one-half hour later the little patient, a very sensible child, rested very comfortable, free from pain and slept a few hours soundly. About 24 hours later I removed the whole mask from the boy's face and to my great delight and surprise the application had drawn out every kernel of the powder. The inflammation had been greatly reduced, pain was all gone and the face appeared almost natural again with the exception of the sclera of both eyes, which I treated with a solution of cocaine adrenalin.

Another remarkable circumstance is the fact that the boy at the same time got entirely rid of his freckles, not a trace of the latter could be detected.

For about a week the face got anointed with cold cream twice daily, and being well was discharged as cured.

KMS Committee on Physician Impairment and Advocacy

This program provides a confidential, reliable and effective means for the medical profession to identify, evaluate, refer for treatment and monitor those physicians whose ability to practice is impaired. For information, please contact the KMS office or the contact person in your area, listed below:

Judith A. Janes, C.C.D.P.1-800-332-0156

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RBRVS: Good for Patients — and Physicians

WILLIAM D. HOADLEY, M.D.,* *Kansas City*

When the Resource-Based Relative Value Scale first came onto the health policy scene, physicians supported it because it would introduce fairness and rationality into the Medicare payment system, unite the medical profession and, most of all, because it would be good for patients. But lately I've been hearing many of my colleagues say they've become disillusioned with the RBRVS's implementation. They don't trust the federal government to live up to its end of the bargain.

Well, I don't trust the federal government to live up to its end of the bargain, either — at least, not without concentrated pressure to do so. But I don't think the medical profession should write off the RBRVS. Despite many problems, some immediate and some potential, it still will do what it was intended to do.

For instance, under the RBRVS, relative values are expected to increase substantially for most evaluation and management (E/M) services. Skeptics have suggested that the RBRVS will be used only to cut surgical values — and fees. New estimates show, however, that the RBRVS will increase relative values for E/M services by 30% on average, and that as a result, Medicare payments for these services still will increase substantially above 1991 payments under a "budget-neutral" RBRVS fee schedule.

Better yet, the RBRVS protects undervalued evaluation and management services provided by all physicians — *even when the budget is cut*. Consider what would happen to a \$30 office visit from 1991 to 1996 under a purely hypothetical scenario in which fees normally would have been given a 15% inflation update, but Congress cuts

"The RBRVS protects undervalued . . . services provided by all physicians — even when the budget is cut."

payments 10% below inflation. In 1996, that same office visit fee would total \$31.05 without the RBRVS. But with the projected 30% gain for E/M services expected under the RBRVS, it would total \$40.36. Especially in this budget-cutting climate, the RBRVS will protect fees for the E/M services *all* physicians provide.

Exactly what effect there will be on an individual's practice depends on several factors, however. Because of elimination of geographic differentials and limits on balance billing, for some there will be no actual gain (and possibly even a reduction) for E/M services. Where physicians practice, how often they accept assignment, how much they charge in excess of Medicare's "approved amount" for unassigned claims and their mix of services will determine the effect on their practices. But regardless of each individual's gain or loss, the RBRVS will enhance payments overall for physicians' E/M services, compared with what would have been.

Another benefit is that the RBRVS allows physicians to unite for a fair conversion factor and to oppose further cuts in the Medicare program, rather than engaging in internal squabbling. The conversion factor that makes the RBRVS into a real fee schedule applies to *all* physician services. That means the entire profession has a stake in making sure it's fair and an incentive to work *together* to stave off future Medicare cuts. In fact, every medical group that testified before the Physician Payment Review Commission last December, including the American Medical Association, the American Society of Internal Medicine, the

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American Academy of Family Physicians and the American College of Surgeons, opposed HCFA's proposal to lower the conversion factor. HCFA has indicated it will assume volume will increase, and that it will set the conversion factor lower to make up for that assumed increase.

The RBRVS also provides a basis for opposing unfair cuts in specific procedures. For example, the profession can argue that the ban on reimbursement for most EKG interpretation is contrary to the RBRVS, because the study said the service indeed has a value. The influential Physician Payment Review Commission agrees, giving the profession a real opportunity to get this cut reversed. Without the RBRVS, it would have been far more difficult to make that case.

Continued support for the RBRVS allows the profession to be *for* — not just against — something. If it wasn't for the medical profession's support for the RBRVS, we'd all be worse off. No one can say that change wasn't coming. Those who don't like the RBRVS and limits on balance billing should consider the alternatives: mandatory assignment, MD-DRGs, and fees set by the government without any professional input. The

(Continued on next page.)



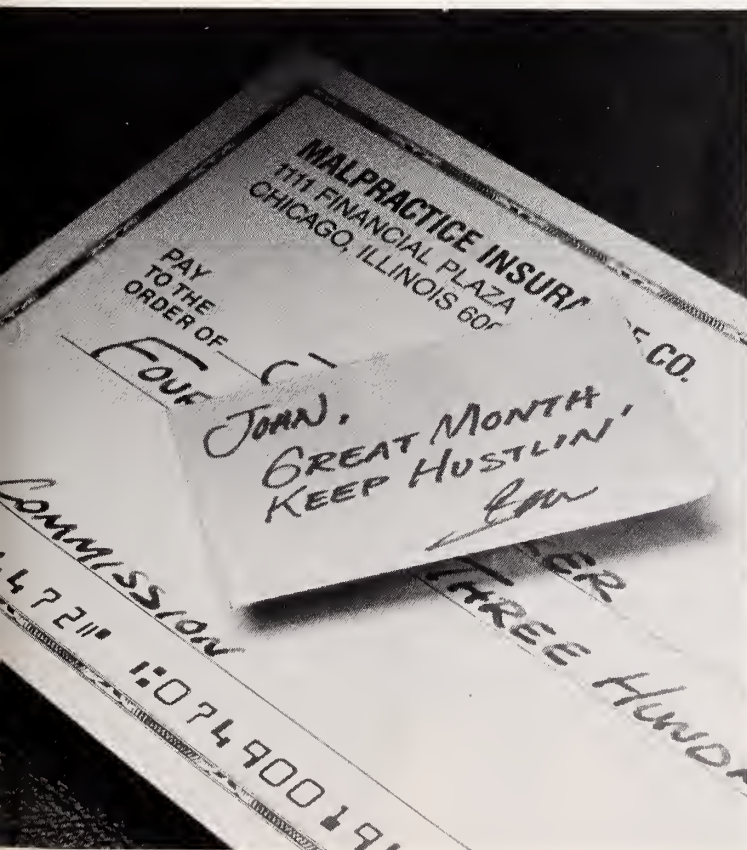
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**“Finally, and most important,
the RBRVS is good for our
patients.”**

So, to paraphrase Mark Twain, reports of the death of the RBRVS are greatly exaggerated. But medicine can't just assume that everything will turn out okay. We must fight to preserve the promise of physician payment reform.

That means opposing policies that will undermine the RBRVS (such as a behavioral assumption that would lower the fee schedule conversion factor). It means working to change policies — such as the ban on reimbursement for EKG interpretation — that give with one hand and take away with the other. And it means supporting further changes that will make the system even better.

The RBRVS unites physicians under one fair and rational payment system to fight future detrimental budget cuts in Medicare. Lawmakers faced with a divided “house of medicine” easily can use that division to cut Medicare payments even further. But if they're faced with a profession that's united under the RBRVS, it won't be so easy.

Support for the RBRVS has been right — for our profession and for our patients. The RBRVS will protect undervalued evaluation and management services in an era of Medicare budget cutting, increase access and the emphasis on preventive care for patients, and introduce fairness into the Medicare payment system. But we must fight together — as a profession — to make sure it is implemented in the way Congress intended.

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Hemobilia from a Ruptured Hepatic Artery Aneurysm

PATRICK L. SCHROEDER, M.D., AND A. JASON TREGO, M.D.,* *Wichita*

Hepatic artery aneurysms are relatively rare vascular lesions which confront the clinician with a significant diagnostic and management challenge. Rupture of these lesions can result in hemobilia (hemorrhage into the biliary passages). Hemobilia is a very unusual complication following percutaneous liver biopsy, but, when seen, is commonly associated with abdominal pain. We present a patient who experienced severe abdominal pain six weeks following a liver biopsy. Hemobilia was subsequently discovered at surgery.

Case Report

A 53-year-old white female entered the emergency room after the abrupt onset of right-upper-quadrant pain. The pain radiated through to the back and right scapula and was accompanied by nausea. Abdominal films were negative, but an abdominal sonogram showed development of a large, nonechogenic mass in the gallbladder since her previous hospitalization. She had been hospitalized six weeks earlier for a bout of acute hepatitis A (anti-HAV IgM positive) and had undergone a percutaneous liver biopsy.

On examination, she was afebrile but lying curled up on her left side to relieve pain. Abdominal examination showed diffuse moderate tenderness; the liver edge was nontender and palpable 4 cm below the right costal margin. Bowel sounds were hyperactive. There was no rebound tenderness, nor were there masses or bruits. Admission laboratory reports showed a WBC of 12,000/mm³ with no immature forms; hemoglobin 12.1 gm/dl; and hematocrit 35.4%. The AST was 114 U/L; ALT 68 U/L; alkaline phosphatase 142 U/L; GGTP 104 U/L; and lactate dehydrogenase 640 U/L. Prothrombin time and activated partial thromboplastin time were normal.

The patient was admitted to a general medical floor with a presumptive diagnosis of acute cho-

lecystitis. Her symptoms failed to resolve with conservative measures, and she was taken to surgery, where a tense, edematous gallbladder was found. The mass in the gallbladder identified by sonography was retained blood. An intraoperative cholangiography revealed longitudinal filling defects in the common bile duct, and common duct exploration showed the filling defects to be blood clots. During the exploration, a well organized blood clot was removed from the right hepatic radical. This was followed immediately by brisk bleeding. Hemostasis was obtained, but the source of the bleeding could not be identified. The common duct was closed, and arteriographic delineation of the arterial anatomy was scheduled. Postoperatively, she hemorrhaged through her T-tube, and an emergent arteriogram identified a right hepatic artery aneurysm. Attempts at arteriographic embolization were unsuccessful. She returned to surgery for ligation of the right hepatic artery, after which she had no further complications. The patient was dismissed in stable condition one week later.

Discussion

Aneurysms of the visceral branches of the abdominal aorta are uncommon. The splenic artery is the most commonly involved branch and accounts for 60% of such lesions. The hepatic artery is the second-most-frequently involved site, but aneurysms of this vessel account for only about 10 to 20% of all visceral-artery aneurysms. They are usually diagnosed at autopsy or found at laparotomy. Kirklin reported the first case demonstrated by preoperative angiography in 1955,¹ and with the advances in arteriography, preoperative identification of these lesions has become more commonplace.

Hepatic artery aneurysms have been described in patients from ages 10 to 83 and are more common in males than females (2:1). By 1975, approximately 300 cases had been reported, with only 60 of these being successfully treated.²

The etiology of these lesions seems to be changing in recent times. In the early 1900s, mycotic

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lesions associated with endocarditis made up virtually all cases. Due to antibiotics, by 1977 only about 10% were thought to be of mycotic origin.³ Atherosclerotic changes are the cause in approximately 32% of hepatic artery aneurysms, and these are almost entirely extrahepatic.⁴ Medial degeneration is seen in an additional 24%. Trauma is implicated in 22%, and this includes trauma at the time of operation for other biliary tract diseases or needle biopsy of the liver. Less-frequent causes include polyarteritis nodosa, Marfan's syndrome, syphilis, congenital aneurysms, and inflammation of the gallbladder or pancreas.

The anatomic distribution of these lesions has been relatively constant, as recorded in the modern literature. Eighty percent are extrahepatic, and 20% are intrahepatic. Most intrahepatic aneurysms are secondary to trauma. Extrahepatic lesions are found in the following distribution: 63% in the common hepatic artery, 28% in the right hepatic, and 5% in the left hepatic. The remaining 4% involve both hepatic arteries.⁵ Most hepatic artery aneurysms are solitary, although multiple aneurysms may occur, usually in the setting of systemic arteritis.⁶

Clinical features tend to be nonspecific. Most patients complain of upper abdominal pain not related to meals. The pain, due to distention of the biliary ducts by blood and the passage of clots, is usually in the epigastrium or right-upper quadrant and occasionally radiates to the back or shoulder. When the pain is severe and abrupt in onset, it suggests rupture of an aneurysm into the biliary tree. Physical signs are nonspecific, though one may find a mass, hepatomegaly, or a bruit. Asymptomatic aneurysms may exist for many years, and 80% are not detected until rupture occurs. Both intrahepatic and extrahepatic aneurysms perforate in near-equal incidence. Rupture of extrahepatic aneurysms results in hemoperitoneum, soon followed by death in most cases. Of those that rupture within the liver, 60% do so into the biliary tree. The resultant hemobilia is characterized by Quincke's triad: (1) abdominal pain, (2) gastrointestinal bleeding, and (3) obstructive jaundice. Abdominal pain is the most constant finding, with 80% of patients having this complaint.⁷ Gastrointestinal bleeding is seen in 62% and jaundice in 51%. Bleeding into the biliary tree may be slow, leading to melena and secondary anemia,⁴ or rapid, leading to hematemesis and shock.

In 1973 Sandbloom⁸ reviewed 545 cases of hemobilia. Trauma (accidental and surgical) ac-

"Once the diagnosis is made, aggressive treatment is indicated, since the natural course . . . is progression to rupture."

counted for 49% of cases, although only about 2% of liver injuries are complicated by hemobilia.⁹ Inflammatory processes were implicated in 29% of cases, vascular disorders in 12%, and gallstone disease in 10%. Hemobilia following a liver biopsy is a very unusual complication; approximately 58 cases of hemobilia resulting from a needle biopsy of the liver have been reported in the literature.¹⁰ Symptoms may begin immediately or develop several weeks after biopsy. One possible explanation for a delayed onset of symptoms is injury to the vessel's wall resulting in a pseudoaneurysm, which may dissect over time into a bile duct and produce hemobilia.¹¹

The clinical diagnosis of a hepatic artery aneurysm is difficult to make. There may be a leukocytosis, and serum bilirubin, alkaline phosphatase, amylase and the transaminases may be elevated. Abdominal plain films occasionally show a calcified rim in the upper abdomen, and barium studies may reveal a deformed duodenum due to an extrinsic mass. Ultrasound and CT often show a mass which is frequently misinterpreted as a neoplasm or abscess. The most definitive test is angiography following a high index of suspicion.

Once the diagnosis is made, aggressive treatment is indicated, since the natural course of these lesions is progression to rupture. Intra-arterial embolization is the treatment of choice when technically feasible.¹¹ During the same arteriographic study that identifies the aneurysm, embolization can be performed and a repeat arteriogram can confirm that flow to the involved vessel has been cut off. Embolization has a high success rate (80%),⁹ and a relatively low mortality rate. Unfortunately, embolization was not successful in our patient, and surgical ligation of the right hepatic artery was required.

The origin of this patient's aneurysm and subsequent bleeding into the biliary tract was likely due to her previous biopsy procedure. Although traumatic aneurysms after biopsy are rare, rupture of these lesions can lead to rapid instability of the

patient. Fortunately, this patient had a favorable outcome. However, 80% of patients' lesions have already ruptured when first seen by a physician, and only one in five cases survive, even today.

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MEDICINA ET LEX

(Continued from page 122.)

- and bar the defendant from the same access.
- While the duty of confidentiality exists as to persons not parties to the litigation, the patient no longer has the right to preclude the physician from disclosing facts related to the physician-patient relationship.
 - The court, by this order, does not direct that any physician participate in any *ex-parte* conference with a representative of any party.

Finally, the court concluded:

- Should the witness choose to confer, he may be assured that there is no physician-patient privilege afforded by law as to plaintiff's medical condition or communications related thereto, whether directly related to plaintiff's medical condition giving rise to the litigation or otherwise.

The court's opinion seems well reasoned and should remove many artificial barriers to personal injury litigation. It must be emphasized, however, that the issue probably has not been finally resolved, and other efforts to suppress the informal disclosure of information will undoubtedly be made. As with any requested disclosure of information pertaining to any patient who has not executed an authorization, caution should be exercised by the physician.

CARDIOLOGY NOTES

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to employ lytic therapy will require justification when contraindications are absent.

Anticoagulation with heparin and aspirin should be started during or at the completion of thrombolytic therapy. Patients with reflux sinus tachycardia and/or systemic hypertension should be treated with early intravenous beta-blocking agents. Most other patients should receive oral beta-blockade.

REFERENCE

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Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

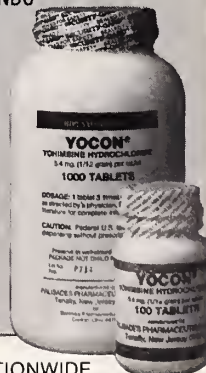
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon[®] 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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New Guidelines for Coronary Thrombolysis

DONALD L. VINE, M.D., *Wichita*

The American College of Cardiology and the American Heart Association have jointly issued guidelines for the management of patients with acute myocardial infarction. The writers define a number of strategies, which they classify into four groups based upon an estimate of appropriateness, efficacy and safety. These guidelines are being provided to government and third-party payers, who may use them to evaluate the necessity and quality of care.

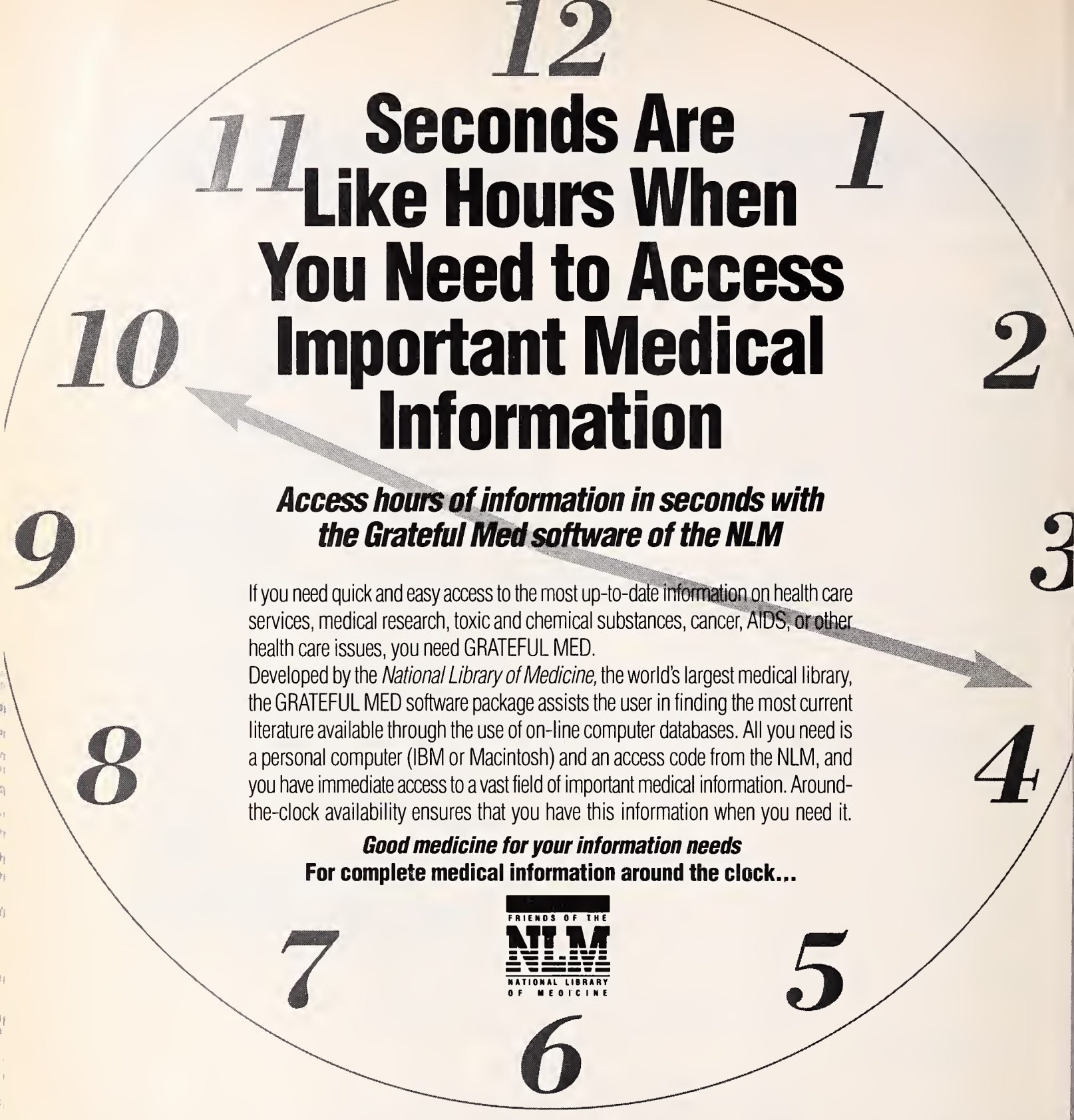
Recommendations for the early use of thrombolytic and ancillary therapy are outlined in the table, and the original article provides a detailed review of the management of patients with acute myocardial infarction.

The bottom line is that prompt thrombolytic therapy is the standard of care for most patients with acute myocardial infarction, and that failure

(Continued on page 133.)

CLASSIFICATION OF STRATEGIES FOLLOWING ACUTE MYOCARDIAL INFARCTION

Class	Description	Thrombolytic therapy	Post thrombolysis
I	Usually indicated, always acceptable and considered effective.	All patients, without contraindications, under the age of 70 with typical chest pain, 1 mV or greater ST elevation in two consecutive leads when therapy can begin within six hours of onset of symptoms.	Intravenous heparin for several days beginning with or after thrombolytic therapy. Aspirin, 160 mg daily. Intravenous or topical GTN for 24 to 48 hours. Early intravenous beta-blockade for patients with elevated systolic blood pressure, tachycardia due to sinus mechanisms or atrial fibrillation, and post infarction angina (absent contraindications to beta blocking agents). Coronary angiography for recurrent myocardial ischemia.
IIa	Acceptable with weight of evidence favoring efficacy.	Patients aged 70 to 75 years who are similar to Class I patients. Treatment later than six hours, with stuttering progression of chest pain. Clinical reinfarction after initial thrombolysis.	Early intravenous beta-blocker for all patients without contraindications. Diltiazem for non-Q wave infarction except in patients with pulmonary congestion or left ventricular dysfunction.
IIb	Can be helpful and probably not harmful.	Therapy between six and 12 hours in Class I patients. Class I patients over the age of 75 years. Patients with less than 1 mV ST segment elevation.	
III	Not indicated, may be harmful.	Treatment later than 24 hours without recurrent chest pain. The cause of the chest pain is unclear or the time of onset is unknown.	
	Absolute Contraindications	Internal bleeding, aortic dissection, prolonged CPR, intracranial neoplasm or head trauma, hemorrhagic retinopathy, blood pressure >200/120 mm Hg, prior hemorrhagic CVA.	For Beta Blocking agents: Heart rate less than 60, systolic blood pressure less than 100 mm Hg. Moderate to severe left ventricular failure. Peripheral hypoperfusion. PR interval greater than 0.22 msec or AV block. Severe chronic obstructive lung disease.



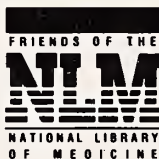
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Notes & Quotes

NEWS FOR AND ABOUT KMS MEMBERS

MAY 1991

KMS Auxiliary Forms New Group

KMSA Partners, an auxiliary support group for spouses and families of physicians, was formed at an organizational meeting in Wichita on April 13. The purpose of the group is to provide confidential and caring support during times of particular stress for physicians and their families, e.g., chemical dependency, illnesses, malpractice suits, etc. The goal of the group is to provide a network throughout the state, thus affording ready access to families and concerned others. Interested auxiliaries are encouraged to contact anyone on the following list for further information or to volunteer their services.

Tucker Averill, R.N.
4404 SW Holly Lane
Topeka, KS 66604
913-272-7096

Ann Gay
1454 Lakeside Drive
Topeka, KS 66604
913-354-8839

Karen Robertson
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316-634-0503

Barbara Robison, R.N.
310 East Walnut, Ste. 204
Garden City, KS 67846
316-276-2612

Linda Wallace, R.N.
1600 North 2nd
Atchison, KS 66002
913-367-4476

Deadline for Mills Trust Applications Is Extended

The Earl L. Mills Educational Trust provides grants for short-term study in any area of medicine or health care. (See KANSAS MEDICINE, February 1991, page 38 for more information.) Kansas physicians are invited to apply for these grants, and the April 15 deadline has been extended to June 30, 1991. Inquiries and applications should be directed to: Earl L. Mills Educational Trust, Kansas State Bank and Trust, KSB&T Building, 123 North Market, Wichita, Kansas 67202.

AMA Offers Support to Desert Storm Physicians

The AMA's Council on Legislation is investigating ways to assist physicians whose practices were adversely affected by their absence while serving in Operation Desert Shield/Storm. Noting that businesses and individuals are entitled to receive government relief after natural disasters, the council concluded that similar "disaster relief" should be available to physicians whose practices were disrupted by the call-up. Such relief could include grants, low-interest loans, deferment of student and business loan payments and increased business deductions. For more information, call the AMA Division of Federal Legislation at 312-464-4764.

The AMA Insurance Agency Inc. has made arrangements to suspend or refund premiums for physicians who were called up for military duty. These physicians need only forward copies of their military orders to AMA Insurance Agency Inc., 200 North LaSalle Street, Ste. 400, Chicago, IL 60601 (tel. 800-458-5736).

KMS Offers Information on Medical Waste Management

Kansas physicians have been receiving advertisements headlined "Re: Violations of Federal Statute 29 CFR 1910.132-1910.141." The promoter seeks to market a videotape on the management of infectious wastes.

The Kansas Medical Society offers the following information on medical waste management. Medical waste in Kansas is regulated by K.A.R. 28-29-27, which defines "medical services waste" as:

"Those solid waste materials which are potentially capable of causing disease or injury and which are generated in connection with human or animal care through inpatient and outpatient services. Medical services waste shall not include any solid waste which has been classified by the [KDHE] secretary as a hazardous waste...or which is radioactive treatment material."

All medical services waste must be segregated from other solid waste at the physician's office. The regulation defines solid waste, storage, collection, transportation, processing and disposal.

The Kansas Medical Society has a package of information on medical waste management that includes a copy of the state regulations and a recent opinion by KMS Legal Counsel on this issue. Contact KMS for a free copy of this information (800-332-0156 or 913-235-2383).

KU Medical School Is Ranked Sixth in the Nation

The University of Kansas School of Medicine has been ranked sixth among American medical schools whose main focus is primary care. This rating was reported in the April 22 edition of U.S. News and World Report, which also conducted the survey of the 66 medical schools under consideration. Information was gathered from officials and intern-residency directors at the schools. The top-ranked institution in the survey is Brown University.

KU Chancellor Gene A. Budig praised the medical school for its achievement, saying, "Kansas has built a strong and responsive school of medicine over the years, and this survey is only the latest confirmation of that fact. We at the University of Kansas are obviously proud of our faculty and their national reputation in primary care."

For the purposes of the survey, primary care was defined as practice in the areas of pediatrics, family practice and general internal medicine. At UKSM-W, psychiatry is also considered a primary care component.

Congratulations

...To the faculty and administration of the KU School of Medicine on their excellent educational program, and ranking in the top ten U.S. medical schools.

...To William J. Reals, M.D., KU vice chancellor, who has received the Chancellor's Award in recognition of meritorious service to the University of Kansas.

...To Robert Manning, M.D., professor and chairman of the UKSM-W Department of Internal Medicine, who will receive an honorary doctor of humane letters degree from the Medical College of Hampton Roads, Norfolk, Virginia, on May 25.

...To Kevin Hoppock, M.D., a recipient of a 1991 Mead Johnson Award for Graduate Education in Family Practice. The awards are given to outstanding residents based on their leadership ability, community involvement and exemplary patient care. Dr. Hoppock is entering his third year in the Wesley Family Practice Residency Program in Wichita.

KANSAS MEDICINE

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June 1991

Volume 92, Number 6

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Official Proceedings
Unicompartmental Knee Arthroplasty



KANSAS MEDICINE

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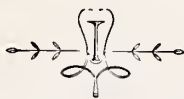
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**ABOUT OUR LOGO**

In January 1935, a new logo appeared on the cover of KANSAS MEDICINE for the first time. This device represents two stethoscopes: the original monaural type as used by Laënnec, and the modern binaural variety. The logo was designed expressly for KANSAS MEDICINE by renowned graphic designer Bradbury Thompson, a native of Topeka and friend of two former editors of the journal, Dr. W.M. Mills and Dr. Lucien Pyle. As another former editor, Dr. Orville R. Clark, wrote in January 1955, the logo "has become as much a part of the journal as any of the features on the inside and is something which is ours alone."

As such things go, "The Wheat State" is a satisfactory booster-type phrase — not as cumbersome as "Kansas Grows the Best Wheat in the World" or cutesy as "Land of Ah's," but reasonably supportable by facts. Like such phrases, however, it fails to give a full picture — which is probably impossible.

The full story would have to begin with the centuries of preparation the soil underwent to prepare (unknowingly) for the present day. It would have to mention in passing that the Spaniards, who were the first from that other world to check it out, were in fact impressed by its fertility but, not finding the gold they sought, decided to skip it. The natives failed to develop the land in a way that would please present-day agricultural economists, using it only for their modest needs. Living close to nature, they respected it, though it can be said they were never confronted with the current pressures regarding productivity. It should be recalled that this soil supported the grasses which, in turn, supported the animal life, notably the buffalo — which provided those natives with food, shelter and clothing. But the pressures were brought by a relentless extension of human inhabitants.

Whether one condemns or condones the present cultural state, it is a product of the long story of things — glaciers, floods, disease, war — which constitute the world's history. By such reckoning, it is only yesterday that the seed wheat was brought to the opening area. The story of Turkey red is well known, but it is also the story of the people who brought it here and in the process determined a major part of Kansas' history and character.

The ritual goes on: the planting, the early growth, the caprices of weather which hold the whip hand. The grasshoppers have never matched their success of 1873, but they and other threats must be constantly recalled. An afternoon of hail or a long rainy spell can destroy a year of effort and bring financial deprivation.

But finally, if all goes well, the time comes. The combines begin their annual statewide trek from south to north, and Jim Hamil's watercolor catches this climactic phase. In the combines' path, grain elevators will fill. Even streets may serve as repositories of wheat awaiting the now-vital railroad cars and trucks that will take it to distant mills. And the nickname "The Wheat State" is ours for another year.

Great Expectations

Sighting a recent article in the *JAMA* with its complementary editorial brought back memories from nearly 40 years ago. The substance of the article was a report that a study of cases in which a bad outcome occurred brought a higher percentage of findings of inadequate care than comparable cases in which the patient survived. The clear-cut message was that, in retrospect, we are inclined to judge the management of a case as faulty by the outcome rather than by the merits of that management as it occurred. Not too surprising, really, since human nature (that marvelously undefined but always understood entity) is prone to accept the finality of the negative results, rather than the circumstances leading to them.



Our memories were of the early days of the still-continuing study of maternal deaths in the state. It was (and is) a sincere effort to examine the background events so tersely reported in the death certificates of parturient women — an educational rather than punitive effort. The involved physician was interviewed and invited to attend the subsequent discussion by the Maternal Welfare Committee. Whatever else it accomplished, it resulted in accumulation of some statistics.

The impact of those *JAMA* articles was to bring back the occasion of our being called upon to present a paper at a professional society meeting. Having little we recognized as outstanding or exciting in our practice, we decided to present some of those statistics but, also aware that such reports can be downright boring, we decided to try to attempt a little interest. We had recently had a case of a postpartum patient who had developed complications not within the usual postpartum agenda. Neither we nor an internist-consultant could satisfactorily define or treat them, and we felt impotent, since death seemed a very likely possibility. Consequently, we were both surprised and relieved when the patient began to get better and did, in fact, recover completely in time. (Today, there are undoubtedly esoteric studies and procedures which would have resolved the matter but — well, a lot has happened in those years.)

We decided, for our presentation, to offer the case (anonymously) as if the patient had, in fact, died — and call for discussion of what had been

done. It was our hope to provoke some attention to that fine line between survival and death which determines whether we are saints or sinners. We always felt that the presentation was something of a fiasco, since it brought no evidence from the audience of admiration or professional profit or even understanding of what we were trying to do — rather puzzlement, boredom or looks suggesting it would probably be wise to lock us up. (It did provoke a little embarrassment from some of those who had lambasted the attendant when they learned it was our own case — and the patient did survive.)

If this was before the current availability of diagnostic and treatment modalities that might have helped us, it was also before the days of peer review and the management-by-committee policies being thrust on the profession these days. And, of course, it was before the days when malpractice suits are almost *de rigueur* in obstetrics. But one thing abides through the centuries: when something goes wrong, the physician is suspect. One of the unfortunate aspects of this technological age is that the loss of the more personal patient-physician relationship (which at one time comforted both through many problems) makes such hindsight judgments easier for the public to accept.

It seems to us that this study is of considerable significance not simply because it offers a little objective basis for this “post hoc” impression but, with a change of venue, it applies to every step of the medical effort — methods of delivery, payment, legal implications and, overall, the quality of medical care. Has there ever been a case of medical care which, in retrospect, could not have been handled better? True, we have all thrived on the occasional case in which we felt great satisfaction with the care and results. That feeling is necessary to carry one through those cases in which we experience the less satisfactory — though technically successful — results.

But we are reminded that the judgment of medical care today derives from the translation of medical circumstances into terms and references comprehensible to the full spectrum of social forms. If there is a malaise afflicting the medical profession, it stems from the feeling that, however justified its efforts — and however successful by pure medical standards — it lives with the threat of being found wanting. D.E.G.

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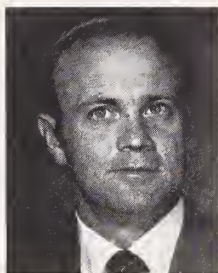
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On Universal Access to Health Care

The AMA has its Health Access America proposal, the AFL-CIO its Grassroots Agenda on Health Care, the Kansas Legislature its Commission on the Future of Health Care, Inc., and most major players in health care have comparable statements or study groups reflecting the fact that our health care delivery system needs change, must change, and will change whether or not you or I want it to. At a recent AMA Leadership Conference, AMA Executive Vice President James Todd, M.D., told us, "Physicians tend to reject leadership and dream about the way things used to be." Lane Kirkland of the AFL-CIO addressed that same Leadership Conference, and it is difficult to find any fault with his statement that "we must provide health care access to *all* as the basis for a *morally* acceptable health care system." (The italicizing is mine.)



Universal access seems to be a common theme in every discussion on health care, although universal access does not in each instance imply universal access to all possibly beneficial modes of health care technology. In the April 8, 1991 *American Medical News*, Dr. Todd states, "Every American ought to have access to a *defined* level of care, regardless of his or her ability to pay for it." (Again, the italicizing is mine.) To me, words such as "defined" and "basic" are synonymous with — but less inflammatory than — the words "rationed" or "prioritized."

The term prioritized seems to have its origin in the Oregon state debates on health care and is the term I favor, as it implies an attempt to allocate available resources in such a way as to do the most good for the most people. With KMS cosponsorship, Midwest Bioethics Center of Kansas City recently held a two-day conference on the Oregon Health Care Legislation. Several KMS members audited this conference, while Paul Rogers, a former Florida Congressman, directed a panel discussion of the Oregon health care proposals. Senator John Kitzhaber, M.D., President of the Oregon State Senate and an emergency room physician himself, presented the background, thought and effort behind the Oregon Health Care Legislation. The Oregon effort was then discussed,

and in fact to some extent attacked, by physicians, medical researchers and ethicists from across this country and Canada. After two days of debate and discussion, the decision of this international group was that although the Oregon Health Care Legislation effort is flawed, it is still far better than what we have now and seems to be the best alternative available.

The three legislative actions of the Oregon Health Care Proposal will:

- Expand the Oregon Medicaid enrollment to provide prioritized health care services for all individuals at or below the federal poverty guideline.
- Mandate that all employers provide employee health care insurance at a level equal to the prioritized care of the Medicaid population.
- Protect physicians and health care facilities from malpractice suits when services that might

"We must provide access to *all* as the basis for a *morally* acceptable health care system."

have been medically beneficial were withheld because they were not covered services. Employers and self-employed individuals will have the option to purchase their insurance through the State prioritized Medicaid program. Medicare-eligible individuals will still be covered by Medicare, and many employers and/or wealthy individuals are expected to purchase traditional forms of insurance.

Many in the health care industry as well as individuals in federal and state legislative positions are reluctant to accept any change in the current health care delivery system until the "perfect solution" is developed. The dilemma is that our country cannot or will not pay for the "perfect solution," which would be for every American citizen to receive every health care service that

(Continued on page 172.)

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The Board of Healing Arts

WAYNE T. STRATTON, J.D.,* *Topeka*

The Kansas Supreme Court recently had occasion to consider an appeal from an action of the Kansas State Board of Healing Arts denying reinstatement of a physician's license. The physician's license had previously been revoked, based upon unprofessional conduct and professional incompetence. The acts of unprofessional conduct involved the physician's failure to adequately document his patients' needs for schedule II controlled substances. Apparently, the physician had continued to practice in California under a California license, but was anticipating revocation of that license based upon the Kansas proceeding.



The Board of Healing Arts concluded that the physician had not exhibited an understanding that the prior acts for which the license was revoked were serious in nature and inconsistent with the Kansas Healing Arts Act. The physician had secured 50 hours of continuing medical education, but the board concluded that this was done to satisfy the board and was not aimed at improving his professional skills. Only 15 months had transpired since the revocation.

The Supreme Court upheld the action taken by the Board of Healing Arts, and the opinion sheds light on the power and authority granted to the board by the legislature. It emphasizes the judicial approach to administrative review; that is, the court will not interfere in the actions of administrative agencies unless the agency acted arbitrarily or capriciously.

The court discussed the purpose behind enactment of the Healing Arts Act by stating:

*KMS Legal Counsel.

Comments appearing herein are not intended as a substitute for legal analysis or advice. Answers to legal questions depend largely upon the particular facts of a case. The reader is urged to consult an attorney for answers to specific legal questions.

These comments do not necessarily represent the views of KANSAS MEDICINE, or the Kansas Medical Society. For further information, contact Mr. Stratton, 515 S. Kansas, Topeka, KS 66603, 1-800-332-0248.

What must be shown to obtain reinstatement of a revoked license?

The Healing Arts Act is designed to protect members of the public against the unprofessional, the improper and the unqualified practice of the healing arts. Kansas has sought to attain this objective by requiring potential practitioners to be licensed, in the first instance, and by suspending or revoking the licenses of those who are later found to be incompetent or engaging in dishonorable, shady or unprofessional conduct. The purpose both of granting and of suspending or revoking a license is to eliminate the unscrupulous or incompetent doctor from practice of the healing arts.

In affirming the Board of Healing Arts, the court applied the same standards which had recently been followed in a case involving an action to reinstate a disbarred attorney. The court stated that each petition for reinstatement must be considered on its own merits, and that such decisions must be made on a case-by-case basis depending upon the facts involved. The court set out eight factors to be considered in determining whether to grant reinstatement. These are: (1) the present moral fitness of the petitioner; (2) the demonstrated consciousness of the wrongful conduct and disrepute which the conduct has brought to the profession; (3) the extent of petitioner's rehabilitation; (4) the seriousness of the original misconduct; (5) conduct subsequent to discipline; (6) the time which has elapsed since the original discipline; (7) the petitioner's character, maturity and experience at the time of revocation; and (8) the petitioner's present competence and professional skills.

Finally, the court indicated that when one first petitions for licensure, the professional must meet the qualifications required of a member of the profession. When a former professional licensee seeks reinstatement, an even greater burden must be met, and the petitioner must overcome the prior adverse conclusions as to his or her fitness.

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Council District Reports

COUNCIL DISTRICT 1

Having just taken over the unexpired term of Dr. Norm Berkley, I do not have a great deal of news to report from Council 1 at this time. I have had the opportunity to meet with the presidents of all three medical societies in my district. There is a general consensus of the three societies that they desire to continue support of the phase-out of the Health Care Stabilization Fund set for July 1, 1994.

Also, community forums are being discussed as an adjunct to the access-to-care issue developments.

And finally, there are some efforts to obtain increasing financial and staff support for smaller hospitals in our council district from larger metropolitan tertiary-care centers.

John R. Eplee, M.D., *Councilor*

COUNCIL DISTRICT 2

District 2, which is the Wyandotte County Medical Society, experienced a rush of new members and reinstatements following the rescinding of mandatory AMA membership last May. We had a total of 10 reinstatements and 26 new active members from May through December of 1990. This compares to a total of 7 new active members during the same time period in 1989. It appears, at the beginning of 1991, that this has now leveled off. As the dues are collected for 1991, we are seeing about 65% retaining AMA membership.

The Wyandotte County Medical Society, very reluctantly and with much regret, had to end the MEDHELP program on December 31, 1990. This was the cooperative program developed by the medical society to provide free medical care to the medically indigent.

We continue to be plagued with the same problem many medical societies have: poor attendance at society meetings. We have teamed with Johnson County Medical Society in recent years and have had many joint meetings. This has helped somewhat. We recognize that society meetings are on the low end of the priority list, but we feel we are losing the benefits of gathering together outside the influence of a specific entity, i.e., hos-

pital medical staffs and specialty societies. Perhaps society meetings are a thing of the past and no longer needed.

Barbara P. Lukert, M.D., *Councilor*

COUNCIL DISTRICT 3

The Johnson County Medical Society, Council District 3, continues to keep its members and the community updated with important information and to serve the community in a variety of ways. Several members provide medical care for uninsured people, especially children, in conjunction with local voluntary and county agencies. The society has provided judges for the Kansas City Metropolitan Area Science Fair for school children.

In May 1990, Governor Mike Hayden spoke to members of the Johnson and Wyandotte County Medical Societies on how current medical-legal problems are being addressed in the state of Kansas. September 1990 saw Robin Cook, M.D., author of *Coma* and *Harmful Intent*, address our annual legislative dinner, a program instituted to promote better understanding in our community between physicians and legislators. Federal attorney Robert Larsen, a member of the Metropolitan Kansas City Task Force on Alcohol and Drug Abuse, was the featured speaker at the March meeting.

The Kansas Insurance Commissioner candidates, Ron Todd (Republican) and Paul Feleciano (Democrat), debated in a special forum sponsored for doctors by the Johnson County Medical Society in October 1990.

David Chartrand, public relations consultant, helped develop a new brochure to be presented to prospective members, a new logo to be used on all society stationery, and a new format for the "Proceedings."

Pam Johnson, M.D., Chairman of the Drug Education/Bar Liaison, has formed a committee of doctors who work with the Johnson County attorneys to speak to school children about the legal and medical ramifications of drug abuse. Work began in the fall of 1990 to begin addressing the students.

Luncheons sponsored by the Johnson County

Medical Society continue to keep office staffs updated on new ideas and information.

D. W. Bell, M.D., *Councilor*

COUNCIL DISTRICT 6

Council District 6 is composed of the members of the Shawnee County Medical Society. This last year has been an interesting one for us internally. Craig N. Yorke, M.D., a Topeka neurosurgeon, became president in June. Shortly thereafter, one of his partners departed for California, and Dr. Yorke and his remaining partner opened new offices. Being the only two neurosurgeons in Topeka and unable to find an acceptable new partner, Dr. Yorke found it impossible to carry out his duties as president and resigned in October. Robert Barnett, M.D., an OB-GYN, became the youngest president in SCMS history. He will serve out the remainder of Dr. Yorke's term and his own term, as he was president-elect. Dr. Yorke will have another opportunity at the presidency in the 1992-93 year after his practice matters become more settled and he has the time he would like to devote to medical society affairs.

Throughout the year we scheduled a variety of informative and entertaining programs for our monthly meetings. The year began with our June annual meeting, at which KMS President Joseph C. Meek, Jr., M.D., was the guest speaker. In September, we were the guests of Menninger and enjoyed a dinner and program on "Balancing Work and Family." In October the society hosted all candidates for legislative office for a political forum, and in November we treated our spouses to a dinner theatre production of *The Gin Game*. Carolyn Counts of the KMS also spoke to us several times on Medicare and PRO issues, and in March we had a program concerning the "Medical/Legal Aspects of Insurance Payment."

The medical society had input into the guidelines for selection of a new health officer for the Topeka-Shawnee County Health Agency, after Dr. Ray Baker, a longtime SCMS member, left the position last year. Doctors Glenn Bair, Joseph Stein and Gregory Van Sickle, SCMS representatives to the Topeka/Shawnee County Advisory Board of Health, helped with that input.

The past year has been one of increased growth for Shawnee County, due in great part to the repeal of unified membership and creation of KaMMCO. Our membership is currently at 379 physicians, the largest in our history. We mourn the loss of two of our members this past year,

Henry Blake, M.D., and Karl Menninger, M.D.

The medical society office has gone through some changes as well. Two new support staff have been added, and plans are underway for a June move into new, larger headquarters. The new offices will be almost double the size of our current space and will allow us our own small meeting room and more efficient work space. Our referral service has seen an increase in the number of calls and handles about 400 to 500 per month on the average.

Robert D. Durst, Jr., M.D., *Councilor*

COUNCIL DISTRICT 7

The Flint Hills Medical Society followed our traditional schedule of nine monthly meetings per year. In November we were honored to have Dr. Joseph C. Meek, Jr., KMS President, address the society and bring us up to date on current affairs of interest to the members. Jerry Slaughter also attended and addressed various legislative issues and gave us an update on KaMMCO.

The 1991 officers are John H. Steeves, M.D., President; Douglas J. Amend, M.D., Vice-President; A. N. Raju, M.D., Secretary-Treasurer; and Michael L. Montgomery, M.D., Program Chairman.

Two new members joined our society, Dr. Nelson White of Burlington, and Dr. Melanie Byram of Council Grove. In March 1991, St. Mary's Hospital closed its doors for business, leaving Newman Memorial County Hospital as the sole provider of hospital medical services in Emporia.

The members of the Flint Hills Medical Society wish to thank the KMS staff for another year of excellent service to the members of the Kansas Medical Society.

David J. Edwards, M.D., *Councilor*

COUNCIL DISTRICT 8

District 8 has had a fair year. We had an excellent presentation on the status of the Kansas Medical Society in early fall by the President, Dr. Meek. His remarks were well received, but unfortunately by only half of the physicians in Cowley County, as many do not belong to the society.

Our liaison with the Butler-Greenwood Society has not been very active, but we hope that in the future this can be corrected.

The Cowley County Society meets nine months a year with a dinner meeting to which our spouses are invited. Our scientific programs have been

provided by an array of speakers, most of whom have been affiliated with the Wichita branch of UKSM; however, we have recently had programs sponsored by some of the drug companies, and we have had some excellent programs.

Cowley County has two members from Wellington, since the Tri-County Society disbanded, and we are fortunate to have as one of them Dr. Larry Anderson, who is to be our new president of KMS.

Cowley County is having some former members return since unified membership was rescinded. We still have a way to go, but with the quality of our meetings improving, we should steadily increase our membership list. KaMMCO should help this endeavor, since one must be a KMS member to have KaMMCO liability insurance. Everyone believes in the philosophy of KaMMCO, and kudos to Dr. Gleason and Jerry Slaughter for a job well done in getting this off the ground and on sound financial footing.

Kansas is still a great place to practice.

Newton C. Smith, M.D., *Councilor*

COUNCIL DISTRICT II

The Medical Society of Sedgwick County's membership continues to grow, as evidenced by the following statistics: the number of actively practicing physicians increased from 650 to 680 from 1989 to 1990. During the same period, our total membership grew from 847 to 865.

Our activities and achievements during the past year have included the following:

The Society's paging system has been expanded to allow community-wide paging of the 126 rotating residents who are receiving training in the Wichita-area hospitals.

In cooperation with the community's four public hospitals, the society is evaluating the feasibility and/or advisability of organizing and initiating a centralized physician information verification program.

The society continues to work closely with the local EMS regarding medical protocols and is carrying out a study to measure the effectiveness of using MAST trousers on trauma patients.

Meetings with the area's retired physicians and program directors of the community's five free medical clinics were held in late March. Due to new state legislation which allows these physicians to provide medical services on a gratuitous basis to the medically indigent without having to carry the mandated professional liability insur-

ance, it is anticipated that approximately 25 physicians will participate in this program.

Society representatives met with area legislators and SRS representatives concerning problems which need to be addressed if medical care is to be accessible to Medicaid patients.

The society's legislative committee is active, meeting weekly during the legislative session. All proposed bills of interest to medicine are reviewed, after which the committee's views are forwarded to all Sedgwick County legislators.

The Wichita Preferred Provider Association (PPO) has been expanded to include physicians from various areas of the state. We welcome their participation.

Area dermatologists and their staffs will conduct their third annual skin cancer screening clinic on Saturday, May 4, 1991 at the medical society's auditorium.

The society supported a grant proposal for the Wichita Public Schools to obtain funds from the State of Kansas to implement an educational program designed to serve single and teenage parents and all two-parent families who wish to participate in the Parents as Teachers Program by providing information and educational learning experiences relating to child growth and development.

The society continues to be active in the Sedgwick County Health Care Cost Containment Roundtable, Inc., which it was instrumental in organizing 13 years ago. The purposes of this group are:

- (a) To establish meaningful dialogue and experience sharing among health care professionals representing various interests;
- (b) To discuss and disseminate information concerning health care issues at local, state and federal levels;
- (c) To serve as a resource to participants regarding potential new concepts, ideas and approaches to medical cost management;
- (d) To explore and devise mutually satisfactory ways in which the various interest groups involved in health care can work to the overall betterment of the health care delivery and cost system;
- (e) To periodically offer educational opportunities in topical health care subjects for the benefit of participants, their organizations and the community at large.

Tom E. Kendall, M.D., *Councilor*

(Continued on page 152.)

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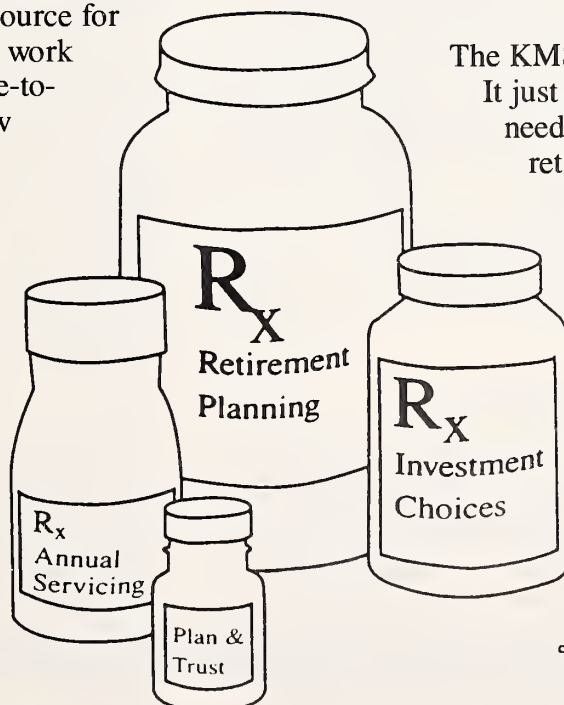
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COUNCIL DISTRICT 12

Our October meeting was well attended. We were privileged to have Dr. and Mrs. Meek, as well as Jerry Slaughter, attend and share their thoughts and activities with us.

Dr. James Monsour established his practice of surgery in Pratt this year, Dr. Roger Mason elected to further his special training in vascular surgery, and Dr. Anthony Wittman moved his practice to Douglas County. Dr. Vernon Filley passed away in February 1991.

Additional primary care physicians are urgently needed in District 12.

L. Theil Bloom, M.D., *Councilor*

COUNCIL DISTRICT 13

As Councilor of the Kansas Medical Society 13th District, I respectfully submit the Councilor's report for the year 1990.

The 13th District saw some changes in KMS memberships following repeal of mandatory AMA membership.

Dr. Meek addressed the CKMS in September 1990, stressing concern over the declining numbers of medical school applicants in recent years.

CKMS sustained the loss of Dr. Phil Brian to Liberal and gained Dr. Charles Schultz, a general surgeon.

At the spring meeting, held on March 28, 1991, new officers were elected. Dr. Ward Newcomb was elected Councilor of the 13th District; Dr. Eric Dyck, President; Dr. Tom McDonald, Vice-President; and Dr. Greg Woods, Secretary-Treasurer. We also distributed KMS materials for the Annual Meeting in May, and District representatives were selected to attend.

CKMS continues to support FHSU endorsement for pre-med student scholarships.

Victor M. Eddy, M.D., *Councilor*

COUNCIL DISTRICT 14

The year 1990-91 marks the first year of KMS membership for a combined Barton-Pawnee County Society, as authorized by the 1990 house of delegates. It is hoped that the combined membership will continue to offer mutual support, an opportunity for social interaction and a continued strong voice in conveying our desires to the KMS. In June the local membership hosted newly elected KMS President Dr. Joseph Meek and local state legislators at a dinner at the Great Bend Petro-

leum Club. Dr. Meek's comments were well received, and areas of concern in health care were conveyed to our local legislators. A new and rather unique function undertaken by the local members was sponsorship of radio broadcasts of KU football games during the fall of 1990. General support for the university and its athletic program, as well as messages of public interest in health care, were broadcast as part of this effort.

Richard C. Preston, M.D., *Councilor*

COUNCIL DISTRICT 15

The 15th Council District has been fairly quiet this year. Our physician population has stayed about the same. There have been some new arrivals, but counterbalanced by some retiring or leaving. I am pleased to report that Seward County Medical Society is much more active and now meets regularly. They are also looking forward to the opening of a brand-new hospital in Liberal.

The Ford County Medical Society continues to meet every other month, with spouses in attendance. Dr. Meek spoke to us in October 1990 and brought us up to date regarding Kansas Medical Society activities. Chip Wheelen gave a report on legislative agendas.

Later in the year, Dr. David Waxman, Director of the Office of Health Care Resources of the Kansas University Medical Center in Kansas City, spoke to the Society on future programs at KUMC.

Two physicians from Ford County were called to active duty and are still serving in the Armed Forces at the time of this writing.

Dr. Melvin Waldorf, of Greensburg, will retire June 30, after having been in Greensburg over 40 years. As of yet, a replacement for him has not been found. Greensburg seems like an ideal town to raise a family and establish a practice in family medicine. If anyone is interested, please contact Dr. Rod Bradley or Dr. Gene Cannata in Greensburg.

Discussions at the medical society meetings usually center around the question, "What is the government going to do to us next?" A bill in the Kansas Legislature, Senate Bill 205, establishing statewide health insurance coverage for all residents, is a particularly onerous bill and has several of us quite concerned.

Senate Bill 38 is also being watched with interest. It is our consensus that the legislature should write the bill to give some flexibility as to the termination date of the Health Care Stabili-

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zation Fund, in case it becomes inappropriate to terminate at a specific time. We also feel that it is critical for "tail coverage" to be included in the bill, as promised by the legislature when the Stabilization Fund was established.

Otherwise things are going well in Western Kansas, except we need rain. Any help will be greatly appreciated.

Clair C. Conard, M.D., *Councilor*

COUNCIL DISTRICT 16

Activities have been disappointingly slow in District #16. In the last few years we have lost many members to retirement or relocation and have been unable to replace them. Myriad causes are perhaps responsible: high malpractice premiums, depressed and depressing rural economy, government demands for more meetings and paperwork, patient demands for instant and constant accessibility, intentional third-party destruction of the traditional physician camaraderie, perhaps even a more technologic and less gregarious style of practice. For whatever reasons, we seem to be less and less involved outside our individual practices. Note that Kansas Academy of Family Physicians' excellent "Doctor of the Day" program had virtually no volunteers from Western Kansas, in sharp contrast to past years.

Our meetings have traditionally been held in association with KU's excellent educational programs, which have become less frequent. We have no plans to dissolve into other component societies, as distances would then assure no participation. The up side is that any members who wish to share skills with KMS committees are accepted with near-obsequious gratitude by KMS leadership and staff.

We pledge renewed effort in supporting the distal end of KMS out here.

John Rand Neuenschwander, M.D., *Councilor*

COUNCIL DISTRICT 17

The Southwest Kansas Medical Society has had four meetings in the past year. The September meeting was highlighted by Dr. Meek, who addressed the current issues of the KMS and of more local interest, indicating that the KU outreach program supplying surgical residents to Garden City would continue. In addition, Jerry Slaughter discussed KaMMCO with the membership.

The November meeting was dedicated to dis-

cussions with the leaders of the KFMC, with James Allen and Jay Schukman, M.D., presenting the program.

In January, Jerry Slaughter presented a program on the functions and responsibilities of the local medical society.

Finally, the March meeting featured Congressman Pat Roberts speaking on rural health issues. This was covered by the local press. The election of officers was also carried out. Calvin Bigler, past KMS President, and his wife, Phyllis, left Garden City for Shiprock, NM, where he has established a surgical practice with the U.S. Indian Health Service.

Bruce D. Melin, M.D., *Councilor*

COUNCIL DISTRICT 18

District 18 had a fall meeting at the University of Kansas Alumni Center with Dr. Meek present. There was a good turnout from the district physicians, and the subject was the effort to improve membership in the Kansas Medical Society. There has been an increase in membership from District 18, and there appears to be a significant level of comfort with regard to current Kansas Medical Society objectives.

After the last election, newly elected representative Walter Hendrix was a guest at the Franklin County Medical Society meeting, and efforts to establish a dialogue between Mr. Hendrix and the physicians were quite successful. The Kansas Medical Society platforms were also presented to Mr. Hendrix, and he seemed to understand the concerns for local physicians and was quite receptive to our input.

Robert A. Gollier II, M.D., *Councilor*

COUNCIL DISTRICT 19

James W. Wilson, M.D., Coffeyville, was elected President of the Southeast Kansas Medical Society for 1991. This society meets nine times yearly, with eight of these meetings being held in Independence and one in Chanute. The meetings consist of dinner, business meeting and a scientific presentation. These are pretty well attended, generally by over half of the members of the Southeast Kansas Medical Society. The education programs are usually arranged by the University of Kansas Health Education Center, which is located in Chanute.

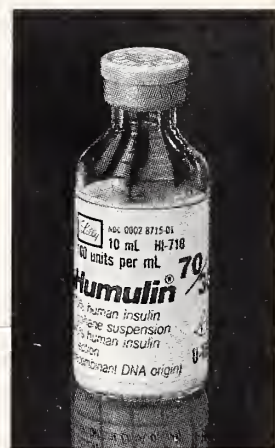
Albert A. Kihm, M.D., *Councilor*

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DISTRICT 410TH

District 410th of the KMS—Saudi Arabian Chapter wishes to submit a report of our past year's activities. We arrived in Saudi Arabia in increments spanning nearly a month. LTC Hal Copple (Ped.—Topeka) was commander of the first group to arrive in late December to help prepare the way into the wilderness. Major Jimmie Browning (FP—Clay Center) led the second increment of 70 soldiers arriving "in country" on January 15, 1991. His group was welcomed by lovely nighttime fireworks displays, compliments of the Iraqi pharmaceutical companies and some of our own U.S. Patriot missiles.

The remainder of the 410th EVAC Hospital from Topeka, Kansas, arrived at our field site northwest of Al Quaysummah at the end of January. A 400-bed hospital was established in the desert. The medical staff numbered nearly 30 with 6 physicians representing Kansas. The rest of the physicians were Army active or reserve doctors from many different states.

We had daily breakfast, lunch and dinner meetings. Social activities included jogging (only on the days we had showers), many cribbage tournaments, and several lively discussions on the proper wearing of gas masks and other military paraphernalia.

Continuing education classes were held regularly, beginning at Ft. Riley and continuing in Saudia Arabia. Many interesting lectures were given on topics such as heat injuries; snake and scorpion bites; leishmaniasis; malaria; and — our favorite — nerve- and mustard-agent prevention, diagnosis and treatment. The latter were particularly well attended.

Care was given to numerous coalition troops, as well as the more numerous Iraqi POWs and the occasional Iraqi or Bedouin family who would wander into a mine field with disastrous results. We had five refrigerated semi-trailers waiting nearby for bodies. By God's grace and the answer to many, many prayers, we put in only one U.S. soldier.

At the time of this writing, we are anxious to dissolve the Saudi district of KMS and eager to be home and active in our local Kansas districts. Please convey our thanks to the 1990-91 KMS leadership and our best wishes to the new KMS president and board. Thank you for your prayers and support.

Jimmie Browning, M.D., *Clay Center*

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1991 Annual Meeting of the House of Delegates

The 132nd Annual Meeting of the Kansas Medical Society began with the joint KMS and KMS Auxiliary Opening Ceremony, at 1:30 p.m. on Friday, May 3, 1991, at the Wichita Marriott Hotel. The meeting was called to order by Kenneth L. Derrington, M.D., Shawnee Mission, Speaker of the House of Delegates. Clifton C. Schopf, M.D., President of the Medical Society of Sedgwick County, welcomed the delegates to Wichita.

Prominent on the agenda was the recognition of physicians who were called up for duty during the Persian Gulf conflict. KMS President Joseph C. Meek, Jr., M.D., invited the physicians and their families to come forward and stand together. A U.S. Marine color guard posted the colors, after which Major Jimmie Browning, M.D., led the assembly in the Pledge of Allegiance. Dr. Browning next presented a special report of the KMS-Saudi Arabian Chapter, District 410th. (For the full text of this report, see the Council District Reports section, page 156.)

Dr. Meek read a special resolution honoring the KMS members who served during Operation Desert Shield/Storm. The resolution was adopted by unanimous consent.

SPECIAL RESOLUTION

Honoring the KMS Members Who Served in Operation Desert Storm

WHEREAS, The recent action of the United Nations to overcome the aggressions of the Iraqi regime required the mobilization and commitment of both active and reserve military forces of the United States; and

WHEREAS, Medical service is, as always, an integral and vital part of that effort in both anticipated and actual care of casualties as well as general and medical support for American and allied forces and civilians; and

WHEREAS, The impact of this effort on the Kansas medical community, these physicians, their families, and their patients was made apparent to Kansans by the calling up of members of the Kansas Medical Society serving in the Reserves; and

WHEREAS, The performance of these physicians reflects the highest credit on the state and

Kansas Medical Society; therefore be it

Resolved, That the Kansas Medical Society expresses its appreciation to the following members for their service and the distinction it brings to our profession and our society:

Donald R. Brada, Wichita
Jimmie L. Browning, Clay Center
Hal E. Copple, Jr., Topeka
Michael J. Keyes, Wichita
Delbert L. Larson, Hiawatha
Gamaliel G. Lotuaco, Shawnee Mission
Thomas G. Mathews, Garden City
Claudia McAllaster, M.D., Leavenworth
Jon M. McMillan, Dodge City
Joseph E. McMullen, Hutchinson
Ambrosio P. Mendiola, Pittsburg
James E. Nixon, M.D., Dodge City
Michael L. O'Dell, Kansas City
C. Stewart Reeves, Fort Scott
John D. Rumisek, Wichita
F. Ronald Seglie, Pittsburg
Martin E. Sellberg, Wichita
Wallace N. Weber, Hays

Jerald R. Schenken, M.D., Omaha, Nebraska, represented the AMA Board of Trustees. He began his report by expressing gratitude to "all the Jimmie Brownings of America." He stated that AMA's Health Access America program has had a dramatic impact on reforming health insurance in the United States. Dr. Schenken said that many medical problems are driven by lifestyles. Also, America's appetite for medical advances puts stress on the system, and third-party reimbursement has depersonalized the physician-patient relationship. Dr. Schenken reiterated that AMA's program is the most realistic, comprehensive and appropriate at this time. Input by all physicians is essential in order to educate the public and find solutions to the crisis, especially in the rural states. Solutions cannot be found in the individual medical, public or political arena; rather, all must work together to find the answer.

Mrs. Sherry Strebel, of Oklahoma City, President-Elect of the AMA Auxiliary, brought greetings from the 70,000 AMAA members, and commended KMS and its auxiliary on the combined opening session, as well as the open partnership that exists between the two organizations. She

described the many projects of the national auxiliary, stating that a new issue to be addressed by the AMAA next year will be violence in American homes, which is reaching epidemic proportions. The primary goal of auxiliary programs is to improve the health of the public.

C.L. (Larry) Montgomery, M.D., Lubbock, Texas, a member of the AMPAC Board of Directors, brought greetings from AMPAC and the AMA Washington office. He enumerated a number of political problems which are placing, and will continue to place, enormous pressure on organized medicine, particularly reapportionment, and exhorted physicians to participate in the political process. He invited James A. Loeffler, M.D., Wichita, Chairman of KaMPAC, to come to the podium and receive on behalf of KaMPAC the 1990 AMPAC Award for membership achievement.

Mrs. Li-Ying Lee, KMS Auxiliary President, commended the KMS Executive Committee and Executive Director Jerry Slaughter for the excellent job they are doing for the physicians of this state. Mrs. Lee expressed her appreciation for the opportunity during her tenure to attend meetings of the KMS Executive Committee and Council, which she found beneficial and enlightening. She mentioned that, thanks to KaMMCO, physicians were able to realize savings on their professional liability premiums. Mrs. Lee encouraged everyone to be generous in contributing to the new KMS Headquarters building. She then gave an overview of the various local chapter activities in the state. Mrs. Lee was honored with a standing ovation for her work with KMS this last year.

The opening ceremonies concluded with a report from KMS President Joseph C. Meek, Jr., M.D., as follows:

PRESIDENT'S REPORT

This morning, when I had the privilege of addressing the medical auxiliary, I expressed concern about the frequent negative comments we hear and read about the medical profession today. Of course, this is not new — the medical profession has constantly struggled to maintain its professionalism. In 1907, as part of his presidential address, my great-uncle, Dr. James Sawtell, admonished his peers to avoid the temptation of fee-splitting in their practices. But still we seem to have great difficulty at times in seeing the special privilege and honor that the doctor of medicine degree bestows upon us.

In one of my favorite plays, *Our Town*, by

Thornton Wilder, a particularly poignant scene occurs near the end, when Emily, realizing how wonderful life on Earth can be, turns abruptly to the Stage Manager and asks: "Do any human beings ever realize life while they live it — every, every minute?" "No," answers the Stage Manager. Then, after a pause, "The saints and poets, maybe — they do some."

And so it is in medicine; these all-too-fleeting glimpses into the fabric of our profession, glimpses that include:

- A family physician's vision of his relationship to his community during a prairie wedding on the high plains;

- The total resolve and commitment of our physicians during times of community disaster and national emergencies: stubborn as the blue-stem grasses that sweep a Kansas horizon;

- The quiet seriousness expressed in a letter I received from a medical student, asking that we make sure that the technologic gadgetry of the computer does not interfere with the direct doctor-patient interaction. This coming from a third-year medical student;

- The steadfast determination of a solo practitioner in a small western Kansas town, who enlists family support and returns a fragile 90-year-old woman to her previous quiet and manageable equilibrium by aggressively treating her life-threatening pneumonia;

- This unending challenge, this inspired commitment, this devotion, this love, this *profession of medicine* — thus it has been, and thus it shall always be.

Thank you for the privilege of being your president.

FIRST SESSION

The first session of the House of Delegates was called to order at 2:30 p.m. by Speaker Kenneth Derrington, M.D., who explained the composition of the House, outlined the rules by which the meeting would be conducted and stated that the House would follow the *Sturgis Standard Code of Parliamentary Procedure*.

The presence of a quorum was announced, and then the minutes of the 1990 meeting were approved.

The Speaker explained the procedure to be followed for the primary election and ordered distribution of the ballots.

The following were appointed tellers for the primary election: David A. Leitch, M.D., Chair-

man, Arun Kumar, M.D., and Newton C. Smith, M.D.

The slate of nominees presented by the Nominating Committee was read:

PRESIDENT ELECT: Richard Meidinger, M.D., Topeka

FIRST VICE PRESIDENT: Arthur D. Snow, Jr., M.D., Shawnee Mission

SECOND VICE PRESIDENT: Donald R. Brada, M.D., Wichita; William D. Hoadley, M.D., Kansas City; and Stephen F. Miller, M.D., Parsons

CONSTITUTIONAL SECRETARY: Mark G. Bell, M.D., Salina

TREASURER: John R. Eplee, M.D., Atchison; and Tom Koksall, M.D., Garden City

AMA DELEGATE: Jimmie A. Gleason, M.D., Topeka

AMA DELEGATE: Lew W. Purinton, M.D., Wichita

AMA DELEGATE: Linda D. Warren, M.D., Hanover

AMA ALTERNATE DELEGATE: Terry L. Poling, M.D., Wichita

AMA ALTERNATE DELEGATE: Frank H. Griffith, M.D., Salina; and Joseph C. Meek, Jr., M.D., Wichita

The Speaker ordered distribution of the primary ballot for the office of Second Vice President. The ballots were collected, and the tellers departed to tally the results.

Dr. Meek assumed the podium to conduct the elections for Speaker and Vice Speaker. Nominated were:

SPEAKER: Kenneth L. Derrington, M.D., Shawnee Mission

VICE SPEAKER: Joseph T. Philipp, M.D., Manhattan.

ATTENTION, KMS MEMBERS!

Please take a moment to check your listing in the 1990 *KMS Membership Directory*. Is everything in it still current? If not, please notify Ramona Perez, Membership Secretary, at 800-332-0156 or 913-235-2383.

New directories will be mailed in August.

There were no additional nominations from the floor.

Dr. Philipp called the delegates' attention to the report of the Constitutional Secretary:

**Constitutional Secretary —
Mark G. Bell, M.D.**

	Year-End 1988	Year-End 1989	Year-End 1990	April 26 1991
ACTIVE	1,934	1,983	2,190	2,196
ACTIVE 2ND YEAR	74	78	63	69
ACTIVE 1ST YEAR	29	26	21	37
PROBATIONARY	68	48	52	58
RESIDENT	277	299	298	282
STUDENT	406	405	401	400
ASSOCIATE	27	32	34	36
PERSONAL EXEMPT	28	31	14	12
RETIRED	405	424	440	444
MILITARY (EXEMPT)				12
EMERITUS	76	77	73	69
HONORARY		1	1	1
TOTALS	3,324	3,404	3,587	3,616

Treasurer —

Donald R. Brada, M.D.

This extensive report was presented in written form and included in the delegates' handbooks. It consisted of financial statements for 1989 and as of December 31, 1990.

Editorial Board —

David E. Gray, M.D.

(The report was read by Warren E. Meyer, M.D., on behalf of Dr. Gray, who was unable to attend the meeting.)

Once again, the Kansas Medical Society gathers for its spring rejuvenation and reminder that every solution brings new problems. It will be noted that the time allotted to the consideration of resolutions has been somewhat reduced, which is not to be interpreted as restricting discussion — but as a warning that you had better talk fast.

With that in mind, I'll report that it hasn't been too bad a year for KANSAS MEDICINE — the journal, that is. I usually have some sad song to sing about our advertising situation, but we are finally resigned to the fact that, with a few happy exceptions, the big advertisers are concerned with a larger market. Nevertheless, our local sources have been gratifying, and we continue our Micawberish optimism about the big bucks.

I call your attention to one change in format that has been recently instituted. The *KMS News-*

letter, which constituted our centerfold, has been replaced by the "Notes and Quotes" column, which will carry general news items. You will receive as a separate mailing a newsletter containing items of specific and pressing importance. In addition, we have initiated a column, "The Way It Was," which reports some items of varying type that we have found hiding in past copies of the *Transactions* or the journal.

I am happy to report that the members of the board and the staff continue to do my work for me, so I am reasonably free to sit at the pile of papers on my desk and drink coffee and look busy. In fact, this brings me to the most agreeable part of my report. Each year, the Sandoz Pharmaceutical people sponsor a seminar on medical publications, part of which involves a competition for various levels of recognition. In the state journal category, a first award and four honorable mention ratings are given. I am pleased to inform you that KANSAS MEDICINE was one of the four receiving honorable mention, along with Florida, Kentucky and Minnesota. While the recognition applied to the journal as a whole, the design and format were given special consideration. It is reasonable to say that we were pleased at this news, and I want to give particular credit to those responsible for it, Susan Ward and Val Braun. And, since he continues to sign the checks, it's only wise to make obeisance to the Business Manager as well. Whatever your acquaintance with the inside of KANSAS MEDICINE, you must have seen the paintings on the cover, and we continue to be grateful to the artist, Jim Hamil, for his talents and for his generosity.

The members of the Editorial Board and those individuals we have called upon from time to time for special manuscript evaluation do the real editorial work of the journal, and my gratitude is measured by the somber realization of what I would have to do without them. And we register our usual invitation to all of you to submit papers since, as always, you are our reason for being. I hope you have noticed that in addition to the standard papers of professional import, we welcome more personalized accounts of physicians' activities and interests.

I also wish to extend our greetings to an old friend and fellow board member, Jack Walker. For many years, he was the representative on the board from the Kansas City branch of the medical school. His current term is completed, and he has expressed the desire not to continue, so we thank him sincerely for his service and for his continuing

interest in KANSAS MEDICINE. We wish him well.

It is time now for the annual ceremony in which the Editorial Board presents to the active but outgoing President a bound copy of KANSAS MEDICINE. He can put in his leisure time rereading his own contributions and the report from our genealogical department while we are digging up material for his unauthorized biography.

(At the conclusion of the report, the traditional exchange of bound volumes of KANSAS MEDICINE took place.)

**Necrology Committee —
David E. Gray, M.D.**

(In the absence of Dr. Gray, Chairman of the Necrology Committee, Dr. Meyer read the following report.)

As you undoubtedly know, the Editorial Board also comprises the Necrology Committee. On its behalf, I submit the following report and cite, as I have on at least one previous occasion, Emily Dickinson's comments:

The distance that the dead have gone
Does not at first appear;
Their coming back seems possible
For many an ardent year.

And then that we have followed them
We more than half suspect,
So intimate have we become
With their dear retrospect.

Since our last report, the deaths of the following members of the Kansas Medical Society have been reported:

<i>Name & City</i>	<i>Age</i>	<i>Date</i>
Victor William Bikales, <i>Overland Park</i>	77	2/13/91
Peter Schott Combs, <i>Leavenworth</i>	76	3/10/91
Hughes W. Day, <i>Overland Park</i>	74	6/18/90
Derrick J. DeSouza, <i>Leavenworth</i>	47	7/3/90
Vernon Warner Filley, <i>Pratt</i>	77	2/10/91
John Howard Gilbert, <i>Seneca</i>	85	3/1/91
George Laurance Gill, <i>Lampe, Missouri</i>	77	5/12/90
Albert Charles Harms, <i>Overland Park</i>	77	1/11/91
Dean Arnold Huebert, <i>Wichita</i>	68	7/11/90
Glen Edward Kassebaum, <i>El Dorado</i>	92	2/15/91
Benjamin W. H. Lafene, <i>Manhattan</i>	89	8/6/90
Francis Xavier Lenski, Jr., <i>Iola</i>	63	10/15/89
Karl Augustus Menninger, <i>Topeka</i>	96	7/18/90
Wilson Eugene Myers, <i>Iola</i>	78	6/20/90
Gaylord P. Neighbor, <i>Shawnee Mission</i>	77	12/12/90
George M. Osgood, <i>Leawood</i>	75	4/19/90
John D. Pace, <i>Parsons</i>	95	5/8/90
Lyle Britain Putnam, <i>Wichita</i>	79	12/30/90
Frederick Walker Rayburn, <i>Topeka</i>	78	4/30/90
Lauren Irving Scaman, <i>Olathe</i>	83	9/7/90
Russell O. Settle, Sr., <i>Topeka</i>	86	12/27/90
Richard L. Sutton, Jr., <i>Leawood</i>	82	8/30/90
Philip Duane Walton, Sr., <i>Hiawatha</i>	58	11/19/90
James Robert Weaver, <i>Wichita</i>	69	10/19/90

KaMMCO —

Jimmie A. Gleason, M.D.

Dr. Gleason reported that during 1990 KaMMCO has been transformed from a startup enterprise into a full-fledged insurance operation. As of January 1, 1991, KaMMCO had insured 747 individual providers and collected \$5.3 million in premiums for the 1991 policy year. KaMMCO's management of the Kansas Health Care Providers Insurance Availability Plan, saving the Plan in excess of \$800,000, has benefited all physicians by lowering operating costs for the Health Care Stabilization Fund.

Dr. Gleason received an ovation from the House of Delegates in appreciation for his effective work on behalf of Kansas physicians. Newton C. Smith, M.D., came forward to make a special personal presentation to Dr. Gleason, a Lladro figurine depicting a handsome obstetrician holding a newborn baby, ready to give it a pat. (Dr. Gleason's specialty is obstetrics/gynecology.)

KMS Impaired Professional Program —

Merle A. Hodges, M.D.

Dr. Hodges encouraged the use of KMS-IPP when indicated, because it is an effective program and one that assures complete confidentiality. The 1990 statistics for this program are included in the committee's report in the delegates' handbooks. During 1990, 55 physicians were referred to the program. Thirty-three are currently being monitored.

Kansas Foundation for Medical Care —

Jay Schukman, M.D.

The past year has been quite busy, with multiple important tasks requiring our attention. However, I would be remiss if I did not give my appreciation to Alex Scott, M.D. Although I gave the annual report last year, it was Dr. Scott's report that I gave. I now finally have an opportunity to thank Dr. Scott for his wisdom and his ongoing counsel concerning this challenging position.

The highlights of this past year's activities include our employment of James E. Allen, M.D., as full-time Medical Director of KFMC. Jim came into the situation at a difficult time and replaced the very capable shoes of Rex Stone, M.D. Unfortunately, Dr. Stone, because of medical problems, was not able to continue as Medical Director. Rex, we miss your ability to navigate waters that are more often than not troubled. However, Dr. Allen has shown himself to be quite capable

of handling the rigors of the position of Medical Director thus far, and I am sure that he will continue that diligence. The Executive Committee and the Board of Directors of KFMC had as one of their goals overall improvement in the review process, including the physician review process. A Quality Review Board similar to that in Topeka has also been organized in Wichita to ease the workload of those in Topeka and to give more representative peer review. One need only look at the names of those on the Quality Review Board to know that they indeed are quality physicians.

The future activity of KFMC is basically that of our contract work with the federal government, namely that of the Health Care Financing Administration. The third scope of work will be completed October 1, 1992. The fourth scope of work will then be negotiated for three years hence. The major changes that will take place include the following:

A. Selection of cases to be reviewed will be done by Health Care Financing Administration in Baltimore.

B. Sampling of cases to be reviewed will include three parts.

1. Five percent random sample of all Medicare beneficiaries who will continue to be followed through review for their lifetime.

2. Five percent random sample of all random Medicare beneficiaries who will have care reviewed for specific increments of time.

3. Specific categories of cases will be reviewed, such as a 25% sample of day and cost outliers, 50% sample of DRG 468 (unrelated operative room procedure) and 100% of DRG 472 (extensive burns with operative room procedure), along with others.

C. Beginning April 1, 1993, review will be performed using the Uniform Clinical Data Set (UCDS), which is a computer system driven by algorithms. A review coordinator will gather and enter information such as laboratory values, medications and vital signs into the computer, and either approval or referral to a physician reviewer will be generated. This system is currently being tested by PROs in seven states. This is being done primarily because the federal government found that there was not a standardized method of how and why charts were reviewed. The first-quarter 1991 KFMC update had a short outline with a summary that basically gives you the information you need concerning UCDS. If you wish to receive that again, please let us know. Overall, what you will be seeing is essentially a centralization

of data into HCFA at Baltimore. At this point, I am not sure if that is good or bad. I do have concerns with the centralization which will need to be observed closely.

Finally, there are our major goals for the future. These include:

A. Improved communication with hospitals and physicians. Ongoing dialogue between the KFMC Board and KMS PRO subcommittee is essential. We are currently discussing methods to control outside utilization review (the so-called 1-800-DOCS) of private insurance companies. This problem is complex because it entails the opening of the Healing Arts Act and subsequent unknown legal and legislative difficulties that may arise. However, I feel at this time that there is an ongoing convergence of ideas concerning this particular area. The Board of KFMC as practicing physicians agree that this is a problem that needs a solution. A forum concerning the KU-Wichita School of Medicine, to improve methods for review for the indigent program, was initiated because of concerns in that area. There is ongoing dialogue with the School of Medicine concerning this area. Members of the Board and I will be available to visit with medical staffs and anyone who has a problem with KFMC.

B. Improved physician review. I want to let you know that I also have received letters from KFMC marked "Confidential." In the past and even currently, I still have significant difficulty with the review process. This is an ongoing, complex problem that can and will be solved. I need your input concerning this and am open to any recommendations that you might have. I do know that we need improved training sessions. Review is essentially a combination of a good fund of knowledge of medicine and common sense. We need more physician reviewers, which also has been an ongoing problem. I would like to compliment the HMSS section of KMS for their concern in this area, particularly with Resolutions 91-14 and 91-15. I wholeheartedly support those efforts. The Second Reviews, which had been centralized in Topeka to a few reviewers, will in the future be mailed out to reviewers in the field so that we may broaden the base of reviewers for Second Review. The overall mechanism for review is also being looked at. Again, if there are any questions, please let us know.

C. We will continue to negotiate with Health Care Financing Administration concerning the changes in PRO contracts that are burdensome, inappropriate or just plain wrong for the health

care providers and patients of Kansas. One of the things that I have found out in dealing and negotiating with HCFA is that they can be quite hard-headed, and we don't always get everything that we want. However, we will continue to deal with it as effectively as we can.

In conclusion, we will continually try to improve how we do peer review. It is not an easy process. My question has always been, if you were going to set up an equitable statewide peer review process so that practitioners from one geographic area could review practitioners from another geographic area in the same specialty, how would you do it? I hope that in the future we can convince the government to move from a punitive stance to that of a self-improvement, educational stance. As long as the solution is political and legislative, and as long as corporate, governmental and consumer accountability is demanded of medicine, we will have to prove that we can and will do effective peer review to improve both the way we practice medicine and patient care overall.

Thank you for your kind attention.

Hospital Medical Staff Section — David A. Leitch, M.D.

Dr. Leitch discussed the three resolutions which HMSS was bringing to this House: centralized credentialing for Kansas, peer review and risk management problems, and pre-admission certification program for psychiatric admissions.

Executive Director's Report — Jerry Slaughter

Mr. Slaughter began his report by saying this is his 18th year with the Kansas Medical Society. KMS has again enjoyed good leadership from the Executive Committee, Council and the various committees. Dr. Meek provided superb leadership with his unique perspective combining experience in the academic environment with medical practice. His particular situation allowed him to be available to KMS at all times.

The Executive Director stated that the professional liability picture in Kansas has improved considerably. He attributed this progress to the efforts of KMS over the past few years, which culminated in the tort reform legislation, as well as the establishment of the Kansas Medical Mutual Insurance Company (KaMMCO). He predicted that access to health care will be the issue of the nineties, and expressed his appreciation for the leadership of Dr. Larry Anderson, who is well

prepared and positioned to lead KMS into the necessary health care reforms.

Mr. Slaughter gave an update on the status of the new KMS headquarters building in Topeka, commended the staff and observed that the Kansas Medical Society exists to serve its members. Any success attributed to KMS is due to physicians' participation in the process.

Mr. Slaughter announced that the 1991 Reference Committee would meet immediately upon the adjournment of the first House of Delegates, and encouraged House members to remain for that meeting and to provide input into those deliberations. He reiterated that the strength of this organization lies in the participation of its members, and asked those present to encourage their colleagues to become active in the society.

James A. Loeffler, M.D., KaMPAC Chairman, briefly addressed the House to inform the delegates that the final version of HB 2454, the so-called ethics legislation, will not prohibit KaMPAC from making contributions to candidates in general elections. He therefore encouraged physicians to respond to the call for contributions.

There being no unfinished business before the House, the Speaker stated that all resolutions included in the handbook were automatically introduced and accepted for consideration. He invited new business, which could be introduced with the approval of two-thirds of the delegates. Resolutions presented were as follows:

91-27 Staff Commendation (Medical Society of Sedgwick County)

91-28 Kansas Blue Cross/Blue Shield Physician Contracts (Medical Society of Sedgwick County)

91-29 Central Credentialing for Kansas (Hospital Medical Staff Section)

91-30 Peer Review and Risk Management Problems (Hospital Medical Staff Section)

91-31 Pre-Admission Certification Program for Psychiatric Admissions (Hospital Medical Staff Section)

91-32 HCFA Medicare Physician Geographic Reimbursement Areas (Larry R. Anderson, M.D.)

The Speaker announced that Resolution 91-4 had been withdrawn by its sponsor.

Dr. Meidinger announced that each handbook contained an evaluation sheet, prepared by the KMS Long-Range Planning Committee. Input by everyone present was solicited. Dr. Meidinger

stated that efforts have been made in the past few years to shorten the time required for physicians to attend meetings. Recently, however, concerns have been expressed that the annual meetings have been shortened to the point of presenting potential problems:

- Specialty societies are finding it difficult to schedule meeting time that does not conflict with the meeting of the House of Delegates;

- Component county medical societies do not have adequate time to receive the Reference Committee reports and evaluate their position on the issues prior to voting;

- Delegates do not have adequate time to think seriously about and discuss the issues prior to voting;

- Opportunities for socializing with peers from around the state have been greatly reduced.

Dr. Meidinger encouraged everyone to complete the five-question evaluation sheet concerning this annual meeting.

The Speaker announced that the following council districts should be prepared to report the name of their councilors for the coming three years: 1, 5, 11, 15 and 17.

The composition of the Reference Committee was announced as follows: Deloris W. Bell, M.D., Shawnee Mission, Chairman; Tom Koksall, M.D., Garden City; Richard L. Rajewski, M.D., Hays; Clifton C. Schopf, M.D., Wichita; and David N. Weidensaul, M.D., Hutchinson.

Dr. Derrington reminded the delegates of the events taking place that evening, including the installation of the KMS President for 1991-92, reception and dance, and the opportunity to gather in the President's hospitality suite. He reminded the delegates that the meetings on Sunday would begin at 7:00 a.m., with Dr. Louis J. Goodman, Texas Medical Association, speaking on the new Medicare payment methodology and on RBRVS, which is scheduled to become effective January 1, 1992. Dr. Goodman's presentation would include both global and Kansas-specific issues concerned with the new payment system, and a quick overview of the outcome with the information available to date.

The second meeting of the House of Delegates will then follow at 9:30 a.m., Dr. Derrington announced. All resolutions will be voted upon at that time. The final election will take place at that meeting as well. The Speaker urged those present to attend the Reference Committee meeting immediately following the first House. Any member of KMS, whether a delegate or not, is welcome

to attend the meeting of the Reference Committee.

The first session adjourned at 4:30 p.m.

SECOND SESSION

The second session of the House of Delegates was called to order by the Speaker, Kenneth L. Derrington, M.D., at 9:30 a.m. on Saturday, May 4, 1991 at the Wichita Marriott Hotel. The Speaker made some announcements and outlined the rules to be followed during the meeting. A quorum was announced, and the ballots for the final election of officers were distributed.

Dr. Derrington then invited Dee W. Bell, M.D., Chairman of the Reference Committee, to begin the Reference Committee Report. Dr. Bell presented the Reference Committee's recommendations on each resolution, and Dr. Derrington invited discussion and voting by the delegates. (The results of those actions are printed below.) After all of the resolutions had been voted upon, Dr. Bell, on behalf of the Reference Committee, expressed thanks to all who appeared before the committee to offer testimony.

The following election results were announced:

PRESIDENT: Larry R. Anderson, M.D., Wellington

PRESIDENT ELECT: Richard Meidinger, M.D., Topeka

FIRST VICE PRESIDENT: Arthur D. Snow, Jr., M.D., Shawnee Mission

SECOND VICE PRESIDENT: Donald R. Brada, M.D., Wichita

CONSTITUTIONAL SECRETARY: Mark G. Bell, M.D., Salina

TREASURER: Tom Koksall, M.D., Garden City

SPEAKER: Kenneth L. Derrington, M.D., Shawnee Mission

VICE SPEAKER: Joseph T. Philipp, M.D., Manhattan

AMA DELEGATE: Jimmie A. Gleason, M.D., Topeka

AMA DELEGATE: Lew W. Purinton, M.D., Wichita

AMA DELEGATE: Linda D. Warren, M.D., Hanover

AMA ALTERNATE DELEGATE: Terry L. Poling, M.D., Wichita

AMA ALTERNATE DELEGATE: Joseph C. Meek, Jr., M.D., Wichita

The Speaker introduced Larry Anderson, M.D., as the new President of the Kansas Medical Society. Dr. Anderson then invited Dr. Derrington

and Dr. Philipp to come forward to be sworn in as Speaker and Vice Speaker.

It was announced that the KMS Council would meet immediately following adjournment of the House, and that the next Annual Meeting will be held in Salina, April 30 through May 3, 1992.

There being no further business, the meeting was adjourned at 11:30 a.m.

Resolutions

Those resolutions that were not adopted but were referred for further study or information are so indicated. The resolutions that failed to pass are retained in the official minutes at the executive office, but are not reported here. An asterisk following the resolution number indicates a change in the Constitution and By-Laws.

RESOLUTION 91-I

Expiration of 1986 Resolutions

"Official policies established through resolutions at the House of Delegates shall be in effect for a period of five (5) years, at which time that policy position will be reviewed by the Executive Committee and will expire subject to the approval by the House of Delegates unless superseded or continued by another resolution."

Attached is a copy of the 1986 resolutions which are scheduled to expire this year. Changes in the bylaws shall remain in effect until such time as they are amended by the House of Delegates.

Recommend re-adoption of:

86-10 — Physician Responsibility and Cost Containment

86-12 — Indigent/Uncompensated Care

86-17 — Medicare Financial Support for Residency Training

86-24 — Smoking & Tobacco Product Sales

86-26 — Motor Vehicular Medical Insurance Coverage

Recommend bylaws remain in effect:

86-3 — AMA Delegates and Alternate Delegates

86-9 — Edwards County Medical Society — Council District 15

Recommend that all other 1986 resolutions expire unless readopted by the KMS House of Delegates.

RESOLUTION 91-2

Commendation for Alex Scott, M.D.

WHEREAS, Alex Scott, M.D., has, for more than 40 years, devoted his energies to the improvement of medical service in Kansas; and

WHEREAS, His faithful presence in the Kansas Medical Society, through activities in the Geary County Medical Society and as 2nd Vice President and membership on numerous committees in the Kansas Medical Society, has advanced the betterment of his profession and the public; and

WHEREAS, He has brought favor to the Kansas Medical Society and benefits to medicine on a national level as Alternate Delegate and Delegate to the American Medical Association for more than 16 years, member of the AMA Council on Long-Range Planning, and a participant in the development of AMA's Health Policy Agenda for the American people; and

WHEREAS, He has demonstrated uncommon interest in his fellow citizens of Junction City, Kansas by service on the City Council and as Mayor of that city; and as Representative from the 65th District of the Kansas House of Representatives; and through involvement in numerous civic enterprises; and

WHEREAS, This remarkable series of accomplishments have brought great credit to the Kansas Medical Society and to the medical profession; therefore be it

Resolved, That the Kansas Medical Society present to Alex Scott, M.D., this resolution of admiration and thanks for these contributions.

RESOLUTION 91-3

Immunizations

WHEREAS, It is the policy of the Kansas Department of Health and Environment to adequately immunize all children in Kansas against MMR, DPT and Polio, and HIB; and

WHEREAS, The costs of these immunizations to private physicians have risen excessively in the last five years; and

WHEREAS, Most Kansas family physicians and pediatricians have discontinued routinely offering vaccinations in their offices due to the high cost of these immunizations; and

WHEREAS, Parents must have their children vaccinated at County Health Departments which is inconvenient due to restrictive hours for vaccination clinics and extra travel and time off of work required by parents who cannot get their

children immunized during physician preventive care visits; and

WHEREAS, It has been proposed that the inconvenience of the present system is leading to increasing numbers of inadequately vaccinated children; and

WHEREAS, The Kansas Department of Health and Environment currently provides vaccinations to County Health Departments (bought with tax dollars at less per-unit cost due to bulk buying); and

WHEREAS, The Medicaid System in Kansas has a system to replace vaccine used by private physicians to immunize children with Medicaid at no charge to physicians or patients; therefore be it

Resolved, That the Kansas Department of Health and Environment be requested to set up a system to provide Kansas family physicians and pediatricians with childhood vaccinations free-of-charge and allow private physicians to administer these vaccines at a minimal cost that covers administrative services only.

RESOLUTION 91-4

HIB Vaccinations

Withdrawn.

RESOLUTION 91-5

Physician-Patient Privilege

WHEREAS, Communication between physician and patient, including information obtained by examination, is Physician-Patient Privilege and deemed confidential (K.S.A. 60-427); and

WHEREAS, A patient must consent to the release of privileged information only as it pertains to himself or herself, or his or her minor child, or individual for whom he or she has been the court-appointed guardian or conservator; and

WHEREAS, A signed and dated authorization to release privileged information applies only to that gathered prior to the date of that authorization; and

WHEREAS, Third-party agents currently gain access to retrospective and prospective privileged information of family members of the primary member of a health insurance and/or managed-care program based solely upon a generic authorization of that primary member; let it therefore be

Resolved, That the Kansas Medical Society actively inform its members of their responsibility in protecting privileged information from said third-party agents; and be it further

Resolved, That the Kansas Medical Society pursue whatever legal action is necessary to protect Physician-Patient Privilege from any abuses by such third-party agents.

RESOLUTION 91-6

RBRVS

Not adopted; referred to the Ad Hoc Committee on RBRVS.

RESOLUTION 91-7

Special Dues Category for Government-Employed Physicians

Not adopted.

RESOLUTION 91-8

KMS-KFMC Relationship

WHEREAS, Endorsement by the Kansas Medical Society is essential for the continued contractual arrangement between KFMC and HCFA to serve as the Peer Review Organization for Kansas; and

WHEREAS, The Kansas Medical Society in Resolution 90-8 reaffirmed and mandated yearly review of its endorsement (as it has yearly for a number of years); and

WHEREAS, The Kansas Medical Society through its various committees and subcommittees has interacted with KFMC in a generally positive and constructive manner; and

WHEREAS, KFMC has publicly stated that pre-certification review is the practice of medicine; therefore be it

Resolved, That the Kansas Medical Society reaffirm its endorsement of the concept of peer review and the policy statement of the Kansas Medical Society *and* the AMA that "peer review is the practice of medicine"; and be it further

Resolved, That KMS endorses KFMC as the PRO for Kansas; and be it further

Resolved, That KMS endorse or not endorse KFMC annually.

RESOLUTION 91-9

Commendation of Martha E. Hunt

WHEREAS, Martha E. Hunt, as Executive Secretary, has devoted 25 years of untiring service to the Wyandotte County Medical Society; and

WHEREAS, During that time Martha Hunt has contributed significantly to the growth and improvement of organized medicine in Kansas; therefore be it

Resolved, That the Kansas Medical Society commends and expresses its deep appreciation to Martha Hunt for 25 years of service to the physicians of Kansas.

RESOLUTION 91-10*

Bylaws Change — Nominating Committee

WHEREAS, Section 6.6 of the bylaws currently requires that 1 or more candidates be nominated for the following offices:

President-Elect
First Vice President
Secretary
Treasurer
Speaker
Vice Speaker
AMA Delegate
AMA Alternate Delegate

and

WHEREAS, Section 6.6 also requires that 3 or more candidates be nominated for the office of Second Vice President; and

WHEREAS, The Nominating Committee believes that it is no longer always necessary to nominate more than two qualified candidates for the office of Second Vice President; therefore be it

Resolved, That section 6.6 of the bylaws be amended to require 2 or more nominations for the office of Second Vice President.

RESOLUTION 91-11

Laser Surgery Qualifications

Not adopted.

RESOLUTION 91-12

Public Education and Development of Rules and Regulations on the Hazards of Tanning Parlors

WHEREAS, The adverse effects of ultraviolet radiation include: skin cancer formation, premature aging of the skin, cataract formation and other eye damage including blindness, impairment of the immune system, photosensitizing reactions with various drugs, initiating and aggravation of certain diseases such as lupus, porphyria, herpes, etc., burns, and occasional death; and

WHEREAS, The American Academy of Dermatology and the American Medical Association encourage educating the public about these hazards, and the development of local and state tanning parlor laws; and

WHEREAS, Laboratory findings of a recent FDA study on long-term threat of skin damage and neoplasms from UVA exposure support the American Academy of Dermatology's Photo-

biology Task Force findings of 1983 that injury from UVA augments skin aging at a faster rate than chronological aging; and

WHEREAS, The Kansas Medical Society would like to educate the public concerning ultraviolet radiation hazards and develop tanning parlor laws; therefore be it

Resolved, That the KMS support an educational campaign on the hazards of tanning parlors, as well as the development of local tanning parlor ordinances to protect our patients and the general public from improper and dangerous exposure to ultraviolet radiation; and be it further

Resolved, That the KMS support legislation to develop and strengthen laws to make the consumer as informed and as safe as possible; and be it further

Resolved, That the KMS submit a recommendation to the Kansas Legislature to implement such legislation.

RESOLUTION 91-13

Peer Review and Mandatory Reporting

Not adopted.

RESOLUTION 91-14

Physician Reviewers for the Kansas Foundation for Medical Care

WHEREAS, The active involvement of a large number of physicians is essential to insure that the review process is fair and appropriate; and

WHEREAS, Currently, a very small number of physicians are involved in the review process, resulting in a limited view of the appropriate practice of medicine; therefore be it

Resolved, That the Councilors and component medical societies be encouraged to recruit as many physicians as possible from their district who are willing to commit up to 10 hours per year of review for the KFMC; and be it further

Resolved, That the Councilors and component medical societies submit these names to the KFMC executive office for consideration; and be it further

Resolved, That the Kansas Foundation for Medical Care be encouraged to assist councilors and component medical societies in the recruitment of physician reviewers.

RESOLUTION 91-15

Expanded List of Available and Utilized Physician Reviewers at KFMC

Not adopted; combined with 91-14.

RESOLUTION 91-16

Tort Reform

Not adopted; referred to Professional Liability Committee.

RESOLUTION 91-17

Phaseout of the Health Care Stabilization Fund

WHEREAS, The Health Care Stabilization Fund was created by the 1976 Legislature to address a lack of available liability insurance for Kansas physicians; and

WHEREAS, The Legislature imposed mandatory liability insurance as a condition of physician licensure in order to assure capitalization of the Fund; and

WHEREAS, The Fund served its purpose during an era when commercial liability insurance was not available to protect physicians and their patients; and

WHEREAS, The physician-owned Kansas Medical Mutual Insurance Company is now a successful provider of medical malpractice liability insurance that assures continuous coverage for Kansas physicians at necessary coverage limits; and

WHEREAS, Other commercial liability insurers will likely offer higher limits of coverage to remain competitive with KaMMCO; therefore be it

Resolved, That the KMS Executive Committee is directed to monitor the status of the Health Care Stabilization Fund closely, including studies and recommendations of the Oversight Committee; and be it further

Resolved, That the Executive Committee shall report annually to the House of Delegates on the status of the Health Care Stabilization Fund.

RESOLUTION 91-18

Kansas Medical Society's Position Regarding Access to Health Care

WHEREAS, It is estimated that over 30 million Americans are without adequate access to medical care, with some 24 million of these individuals being working people and their families; and

WHEREAS, There is general agreement among representatives from the private and public sectors that all Americans should have access to needed basic health care services at affordable prices; and

WHEREAS, The Kansas Legislature considers, almost annually, various proposals which address the question of access to and delivery of health

care services to the uninsured and underinsured, and

WHEREAS, The Kansas Medical Society should articulate a flexible position regarding the subject of access to health care; and

WHEREAS, The AMA has proposed "Health Access America" as its approach to addressing the problems of access and cost of care; therefore be it

Resolved, That KMS support the general concepts of appropriate, accessible and affordable health care for all Kansans; and be it further

Resolved, That the KMS Committee on Access to Care continue to study this problem and report back to the House of Delegates at its next meeting.

RESOLUTION 91-19

Reducing Deaths from Heart Attacks

WHEREAS, Heart attacks are the leading cause of death in Kansas as well as the United States; and

WHEREAS, Pre-hospital emergency medical systems have been and are continuing to be developed and expanded throughout Kansas to provide state-of-the-art emergency medical services; and

WHEREAS, The save rates of persons suffering from heart attacks and related difficulties could be significantly increased if the general public was better informed and aware of their role in managing these types of medical emergencies; therefore be it

Resolved, That the Kansas Medical Society take a leadership role in cooperation with the Kansas Board of Emergency Medical Services in organizing and promoting programs throughout Kansas to further the public's education and awareness of cardiac symptoms; when and how to access established EMS service programs; how to perform effective CPR; develop recommendations regarding the role and training of emergency medical dispatchers and the effective location and use of automatic external defibrillators; as well as other needed services relating to rapid advanced life support programs.

RESOLUTION 91-20

Medical Practice Parameters

WHEREAS, Many medical specialties and other medically related organizations are developing medical practice parameters; and

WHEREAS, Some states, including Maine, Mas-

sachusetts and New Jersey, have considered or are considering allowing evidence of compliance with practice parameters and protocols as an affirmative defense to a malpractice claim; and

WHEREAS, This concept may have potential benefits to medical practitioners from a medical-legal point of view, as well as reducing malpractice insurance premiums; therefore be it

Resolved, That this matter be referred to the Kansas Medical Society Council for further evaluation and report at the 1992 House of Delegates meeting.

RESOLUTION 91-21

Definition of an Expert Witness

Not adopted; referred to the Executive Committee.

RESOLUTION 91-22

RBRVS Model Medicare Physician Fee Schedule

WHEREAS, The Health Care Financing Administration has calculated and released the geographic practice cost indices (GPCIs) to be utilized in developing the RBRVS Medicare physician fee schedule; and

WHEREAS, Serious concerns have been raised by physicians throughout many areas of Kansas regarding inaccuracies contained in the GPCIs, especially relating to the Urban-Rural Designations and the Malpractice Component; and

WHEREAS, Discussions and correspondence regarding this matter have occurred and continue to occur between private practicing physicians, representatives of organized medicine, HCFA and members of Congress, concerning the serious implications of this matter to the practicing physicians of Kansas; therefore be it

Resolved, That the Kansas Medical Society Council and staff continue to monitor all future actions taken by HCFA relating to correcting the errors used in the GPCIs, and if such are not corrected or adequately justified within the allowed comment period before final adoption, that legal counsel be retained to intercede on behalf of Kansas physicians.

RESOLUTION 91-23

Pre-Trial Screening Panels

WHEREAS, Kansas law provides for the convening of pre-trial medical malpractice screening panels; and

WHEREAS, K.S.A. 65-4904(c) states, in part,

that any and all members of the panel may be subpoenaed as witnesses for examination relating to the issues at the trial; and

WHEREAS, Some physicians who have served on screening panels have indicated they probably would not have volunteered to have served had they understood in advance that they would be subject to the subpoena provision; therefore be it

Resolved, That the Kansas Medical Society Council evaluate the pros and cons of maintaining the subpoena provision as outlined in K.S.A. 65-4904(c); and be it further

Resolved, That if it is determined that retaining this provision is not in the best interest of the profession or adversely affects the number of physicians who are willing to serve on screening panels, that an appropriate amendment to this statute be sought; and be it further

Resolved, That at the very least, all physicians prior to their appointment to a screening panel be informed that they are subject by subpoena to testify at trial.

RESOLUTION 91-24

Establishment of Public Relations Department

WHEREAS, In recent years there has been a gradual but definite decline in the public's appreciation for the positive role the medical profession plays in the overall health care of the people of Kansas as well as the United States; and

WHEREAS, The public, through the distortions of the news media, views the physician as a part of the current problem rather than as a vital part of the solution to the problems affecting the nation's health care system; and

WHEREAS, The Kansas Legislature has considered bills regarding access to health care and statewide coverage for health insurance and at the present these bills are in interim study committees; and

WHEREAS, The Congress of the United States will soon consider similar legislation on a national level; and

WHEREAS, There will be a need for physicians to have input at all levels of discussions from the grassroots to the state and national levels showing their efforts to contain and control costs in the face of increasingly complex and costly diagnostic and treatment modalities; and

WHEREAS, The average physician does not have the time or information readily available to com-

bat the misinformation that literally bombards the public; therefore be it

Resolved, That the Kansas Medical Society establish the Public Relations Department to aid the local physician and local component medical society at the grassroots level, and represent the Kansas Medical Society at the state level and work with the American Medical Association at the national level; and be it further

Resolved, That an assessment of \$25.00 be made to adequately staff and fund the department.

RESOLUTION 91-25

Recent Revision of the AMA Physician's Recognition Award

WHEREAS, The AMA House of Delegates adopted a significant revision of the Physician's Recognition Award (PRA) at its 1990 Interim Meeting; and

WHEREAS, This revision now requires 20 hours of Category II credit each year in addition to Category I credit; and

WHEREAS, Reading can no longer be claimed as credit towards the PRA; and

WHEREAS, These changes have led to much confusion and concern among practicing physicians and may lead to increased production of CME programs by non-accredited organizations outside the control of the accrediting agencies (with the potential of a reduction in the quality of programs); therefore be it

Resolved, That the AMA reconsider its action on the PRA revision, and be it further

Resolved, That a resolution be introduced to the June 1991 AMA House of Delegates Meeting requesting a return to prior PRA requirements.

RESOLUTION 91-26

Self Determination Act

WHEREAS, The 101st Congress of the United States enacted the "Patient Self Determination Act," which serves to strengthen the role of patients in health care decision-making, which will be implemented November 1991; and

WHEREAS, Under this legislation providers participating in Medicare and Medicaid will advise patients of their rights to make health care decisions with advance directive such as "living wills" and durable power of attorney for health care; and

WHEREAS, The Kansas Medical Society supports the role of the patient in the health care decision-making process; therefore be it

Resolved, That the KMS notify all Kansas physicians of this act; and be it further

Resolved, That the KMS develop educational information and model implementation policies for use by the Kansas physician for his/her office practice.

RESOLUTION 91-27

Staff Commendation

WHEREAS, Government at all levels, through enabling legislation and subsequent rules and regulations, impacts the practice of medicine and public health, and

WHEREAS, Governmental involvement and intervention in health and medical matters at the state level continues to increase year by year, and

WHEREAS, It is paramount in the interest of the public and the profession that all health and medical issues considered and acted on by the legislature and other governmental entities be carefully evaluated and monitored by the Kansas Medical Society, and

WHEREAS, The physicians of Kansas are most fortunate to be represented at deliberations of medically related matters by two individuals who are not only very knowledgeable of the issues and the legislative process, but are highly respected by legislators, administrators and representatives of other professional groups; therefore be it

Resolved, That special commendation be extended to Mr. Jerry Slaughter and Mr. Chip Wheelen for their diligent work and dedication in representing the Kansas medical profession.

RESOLUTION 91-28

Kansas Blue Cross and Blue Shield — Physician Contracts

WHEREAS, Representatives of Kansas Blue Cross and Blue Shield recently informed representatives of the Kansas Medical Society that major changes are being considered regarding existing physician contracts; and

WHEREAS, An "Expenditure Target"—type payment mechanism to control usage as well as costs is to be submitted to the Blue Cross/Blue Shield Board of Directors at their June 1991 meeting for possible implementation in 1993; and

WHEREAS, It appears that the proposed contract changes may discourage physicians from entering or re-entering participating agreements with Kansas Blue Cross/Blue Shield; and

WHEREAS, It is advantageous to patients insured by Kansas Blue Cross/Blue Shield that phy-

sicians continue as participating providers; therefore be it

Resolved, That the Kansas Medical Society thoroughly evaluate the potential impact the proposed contract changes will have on physician participation in Kansas BC/BS programs, and that this information be sent to KMS members as soon as possible so that all physicians are made aware of the proposed contract changes.

RESOLUTION 91-29

Central Credentialing for Kansas

Not adopted; referred to the Executive Committee.

RESOLUTION 91-30

Peer Review and Risk Management Problems

WHEREAS, Resolution 87-19 authorized the Kansas Medical Society to develop a program to assist small hospitals by providing specialty physician consultation when requested; and

WHEREAS, The PRO Subcommittee recommends that a fair and just mechanism be established to resolve specialty-specialty disagreements between KFMC and the practicing physician, and third party payor-attending physician disagreements; and

WHEREAS, Anti-competitive issues raised in *Patrick v. Burget* necessitate special separation of reviewers from the location of initial activity; and

WHEREAS, There is an increasing need for reviewers in all areas of the practice of medicine; and

WHEREAS, There are 19 specialty groups who have asked for rights of voting and other privileges granted by the Kansas Medical Society; therefore be it

Resolved, That *all* specialty societies holding voting privileges in the Kansas Medical Society be requested to provide the Peer Review and Risk Management Program with a list of previously *contacted and agreeable* specialists (to include at least one in each of the four quarters of the state) to deal with problems in their area.

RESOLUTION 91-31

Pre-Admission Certification Program for Psychiatric Admissions

WHEREAS, The Mental Health Reform Act of 1990 directs SRS to pre-certify all psychiatric admissions to state psychiatric hospitals (and by regulation has been extended to include all acute care hospitals); and

WHEREAS, SRS has contracted with community mental health centers, whose non-physician, allied health professional staff will be performing the required assessments; and

WHEREAS, These agents of SRS are contractually required to interview and evaluate the patients for whom a physician has requested psychiatric admission; and

WHEREAS, This constitutes a consultation with the right to decide intensity of medical treatment; and

WHEREAS, Community mental health center personnel serving as agents of SRS lack the necessary education, training and experience to override the judgment of a physician in charge of a psychiatric patient; and

WHEREAS, The criteria for psychiatric admissions utilized previously, which were developed by the Kansas Psychiatric Society, have been discarded for more stringent criteria developed by SRS staff and community mental health centers; and

WHEREAS, This procedure of overriding a physician-recommended request for admission for an acute psychiatric patient is not sound medical care; and

WHEREAS, This policy appears to be for cost-saving purposes only, and disregards quality-of-care concerns for the Medicaid patient population; therefore be it

Resolved, That all KMS members be notified as soon as possible of the potentially adverse impact of the new SRS policy; and be it further

Resolved, That KMS, in conjunction with the Kansas Psychiatric Society, take other action as appropriate in response to this situation.

RESOLUTION 91-32

HCFA Medicare Physician Geographic Reimbursement Areas

WHEREAS, Separation of urban and rural geographic areas for Medicare physician reimbursement results in an increase for urban reimbursement and a decrease in rural reimbursement; and

WHEREAS, Reduction in Medicare physician reimbursement for underserved rural communities will adversely affect the recruitment and retention of physicians in rural Kansas; and

WHEREAS, Other rural states have recognized the negative impact that multiple regions within a state have on health care delivery and have already petitioned HCFA to change these states to a single geographic area; therefore be it

Resolved, That KMS petition HCFA to designate Kansas as a single geographic area for Medicare physician reimbursement.

RESOLUTION 91-33

133rd Annual Meeting

WHEREAS, The 133rd Annual Meeting of the Kansas Medical Society will be held in Salina, Kansas, April 30–May 3, 1992; and

WHEREAS, We are delighted to be your host; therefore be it

Resolved, That you accept this resolution as an invitation to the KMS meeting in Salina, Kansas, April 30–May 3, 1992.

PRESIDENT'S MESSAGE

(Continued from page 144.)

could reasonably be beneficial. Rather than wait for a consensus on health care issues which may never come, physicians must *now* provide knowledgeable, ethical, effective leadership for health care reform.

Whether the Oregon health care initiatives prove to be a template for other states, and whether organized medicine provides an effective role in the development of a new health care system, is yet to be seen. Without a doubt, however, health care delivery in the future will be based on universal access with increasing concentration on disease prevention, health promotion and careful management of chronic illnesses — as opposed to the expensive, highly technical care of their complications. My question is, "How do we effect physician reimbursement and medical education to provide the thousands of primary care physicians needed to meet the new demand of a health care system based on readily available, continuous, comprehensive, cost-effective health care for everyone?"

Larry Anderson MD

KMS Committee on Physician Impairment and Advocacy

This program provides a confidential, reliable and effective means for the medical profession to identify, evaluate, refer for treatment and monitor those physicians whose ability to practice is impaired. For information, please contact the KMS office or the contact person in your area, listed below:

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Unicompartmental Knee Arthroplasty

WILLIAM GONDRING, M.D.,* AND V. NANDA KUMAR, M.D.,† *St. Joseph, Missouri*

Unicompartmental replacement for osteoarthritis of the knee appears to be a viable concept. One potential advantage of unicompartmental over bicompartamental or tricompartmental knee replacement is preservation of bone stock, anterior and posterior cruciate ligaments, the patellofemoral joint and the normal opposite compartments, to help maintain normal knee kinematics. Other advantages, claimed by various authors, are: shorter operating time, lower cost, less infection and better rehabilitation outcome.

Indications

Unicompartmental arthroplasty was done in osteoarthritis of the knee under these criteria:

- The range of motion of the involved knee is 90 degrees or more.
- There is less than 10 degrees of preoperative flexion deformity.
- Varus or valgus deformity was passively correctable under anesthesia.
- Opposite compartment was confirmed to be normal or near-normal at operation.

This type of arthroplasty was only used in relatively young and "good" osteoarthritic knees, and tibial osteotomy would have been a reasonable alternative treatment in most. It is a common belief that unicompartmental arthroplasty provides less risk of vascular damage than does proximal osteotomy.

Contraindications to unicompartmental arthroplasty include the diagnoses listed in Table 1. Other considerations to contraindication include non-articular deformity, marked bone loss and intraoperative determination of excessive cartilage wear.

Materials and Methodology

The Microloc unicompartmental knee system was utilized. This consists of a metallic femoral re-

placement with porous-coated fixation surface and comes in various sizes. The tapered anterior flange avoids patellar impingement. The tibial component consists of a titanium-alloy tray that allows complete coverage of the tibial plateau and a modular-instrument-tray tibial system made of polyethylene that increases intraoperative options and reduces inventory costs. The design is intramedullary as well as orthomedullary. Both were either cemented or uncemented.

Twenty patients with unicompartmental knee arthroplasty were followed for periods ranging from 6 to 25 months. The median age of the group was 64 years. The youngest patient was 56 years of age and the oldest 72. Nine patients were males and eleven were females. All of them were operated on medial compartment. All were diagnosed as suffering from osteoarthritis of the medial compartment of the knee. Eight of the twenty were considered obese patients. The knees were scored preoperatively and postoperatively by the Hospital for Special Surgery (HSS) knee rating system. Under this system, a score of 85–100 was excellent, 70–84 was good, 60–69 was rated fair, and below 60 was poor. A removed prosthesis was rated as 0. The strength of the quadriceps and hamstrings, and range of motion on the affected side were studied by using a Cybex machine. X-ray of each involved knee was done pre- and postoperatively (Figures 1 and 2). The varus or valgus deformity of the knee was measured before and after surgery. The pain in the knee was rated on a scale of 1 to 4, pre- and postoperatively.

Results

Pain was the main indication for surgery. All the

TABLE 1
CONTRAINDICATIONS TO
UNICOMPARTMENTAL ARTHROPLASTY

Inflammatory arthritis	Psoriatic arthritis
Rheumatoid arthritis	Hemochromatosis
Systemic lupus erythematosus	Chondrocalcinosis
Ankylosing spondylitis	Hemophilia
Juvenile rheumatoid arthritis	Osteonecrosis
Inflammatory bowel disease	Obesity

*Chief of Surgery, Heartland Hospitals.

†Medical Director, Physical Medicine & Rehabilitation, Heartland Hospitals.

Address correspondence to Dr. Gondring at St. Joseph Orthopedic Associates, 1335 Village Drive, P.O. Box 8067, St. Joseph, Missouri 64508.

Figure 1. X-ray of the knee showing osteoarthritis of the medial compartment.



Figure 2. X-ray of the knee with unicompartmental arthroplasty.



patients were categorized in one of three groups. Group I consisted of seven patients who rated the pain at 4 (highest on a scale of 1–4). Group II had seven who rated the pain at 3, and the six in Group III rated pain at 2 (Table 2).

The scoring of the knee was compared pre- and postoperatively. Preoperatively, none scored above 85. Two patients scored between 70 and 84, five patients between 60 and 69, and 13 scored below 60. Postoperatively, 18 patients scored 85–100 (excellent), and 2 scored 70–84 (good). (See Table 3.) In all cases, there was varus deformity ranging from 1 to 10 degrees. Postoperatively, the varus deformity was converted into valgus deformity of 1 to 10 degrees, except in two patients in whom it was neutral.

TABLE 2
GROUPS OF PATIENTS WITH VARIOUS
LEVELS OF PAIN PRE- AND POST-OP
1 IS MINIMAL PAIN; 4 IS WORST PAIN

Group	Number of Patients	Preoperative Pain (1–4)	Postoperative Pain (Average)
Group I	7	4	1.4
Group II	11	3	1.0
Group III	2	2	1.0

TABLE 3
RESULTS OF UNICOMPARTMENTAL
KNEE ARTHROPLASTY

Points	Number of Knees	
	Before Operation	After Operation
Less than 60	13	0
60–69	5	0
70–84	2	2
85–100	0	18
Mean score	48	88

Complications

No cases of infection were reported in this series, but 4 patients manifested clinical evidence of pes anserinus bursitis and 8 demonstrated a valgus deformity between 6 and 8 degrees. Three weeks postoperatively, one patient developed a cerebrovascular accident, which was considered unrelated to the surgery. No loosening of the prosthesis was reported.

Discussion

In the authors' opinion, unicompartmental knee arthroplasty is a good operative procedure for osteoarthritis of the knee in the elderly. The alternative treatment of proximal tibial osteotomy is associated with prolonged convalescence and higher morbidity. The present study shows excellent results in 90% of the knees studied and good results in 10%, with a very low overall complication rate. In general, good pain relief and good rehabilitation outcome were noted. The complications noted are either transient or asymptomatic.

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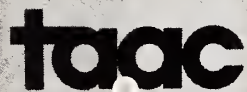
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The author will be asked to review the **galley proof** prior to publication. Although editing and proofreading will be done with care, the author is responsible for accuracy of material published. The galley proof is for correction of **ERRORS**; rewriting of material *must* be done prior to submission. Authors are urged to check manuscripts and galley proof carefully for errors that could result in inaccurate information.

Drugs should be referred to by generic names; trade names may follow in parentheses if useful. All **units of measure** must be given in the metric system.

KANSAS MEDICINE will print a maximum of **ten references**. All references should be keyed with superscripts in the text in the order cited. If more than ten sources are cited, readers will be referred to the author for the complete list.

Illustrative material must be identified by its referral number in the text and be accompanied by a short legend. **Photos** should be black-and-white glossy prints. **Tables** should be self-explanatory and should supplement, not duplicate, the text.

KANSAS MEDICINE will assume the cost of black-and-white figures and tables for two units. A unit is defined as $\frac{1}{4}$ page. The author(s) will be billed for additional units at cost.

A **reprint** order form with a table showing estimated cost will be sent with the galley proof. Reprints must be ordered by the author through KANSAS MEDICINE, and will be billed to the author following shipment.

THE WAY IT WAS

From *The Journal of the Kansas Medical Society*, Vol. II, No. 12, May 1903:

... Another thing: the reason why patent medicines are so popular is largely in the amount of alcohol to be found in the medicines. This gives the well known exhilarating [sic] and care freeing effect of alcohol to the concoction and the patient being made unconscious of his misery loudly praises the "medicine" taken. When it is remembered that beer contains only 3-5 per cent. of alcohol, wine 10-15 per cent. and even brandy and whiskey only 45-60 per cent. it will be seen that patent medicines are not to be classed among non-alcoholic drinks. Thus Dr. Bumgardner finds the following percentages of alcohol in the "medicines" named:

Greene's Nervura	17.2
Hood's Sarsaparilla	18.8
Schenck's Sea-weed Tonic	19.5
Brown's Iron Bitters	19.7
Kaufman's Sulfur Bitters	20.5
Paine's Celery Compound	21.0
Burdock Blood Bitters	25.2
Ayer's Sarsaparilla	26.2
Warner's Safe Tonic Bitters	35.7
Parker's Tonic	41.6
Hostetter's Stomach Bitters	44.3

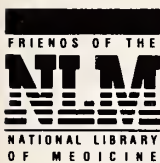
From a consideration of these percentages it will be quickly seen why physicians do not put much faith in W.C.T.U. [Women's Christian Temperance Union] and church workers, who preach total abstinence and yet maintain their own vigor on patent medicines. It is one of the shames of our churches that the avowedly church papers sell their space so freely to vendors of patent medicines. They are working injury to the cause which they profess to further.

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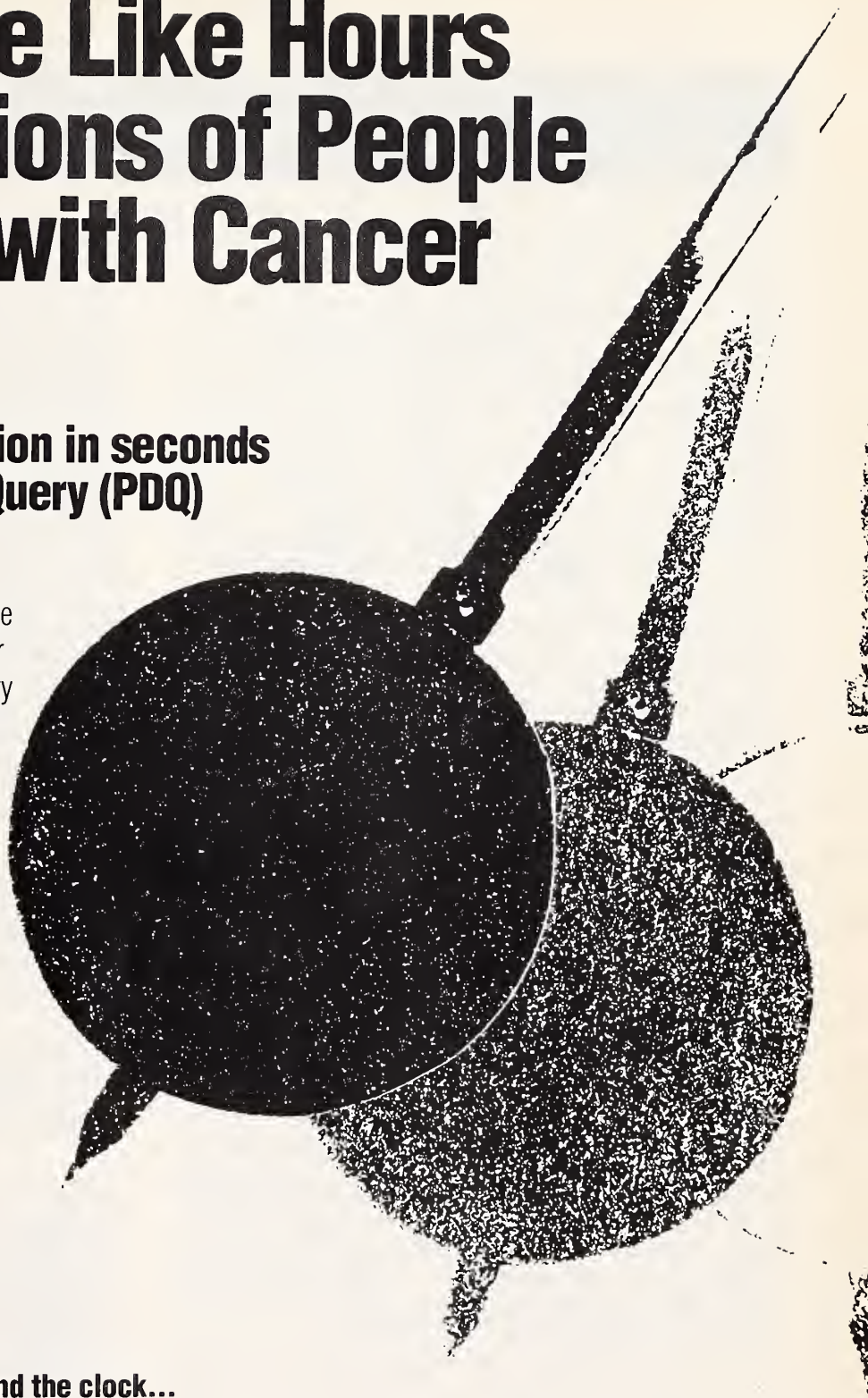
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PSYCHIATRY POSITIONS. Psychiatry recruitment firm is recruiting for private psychiatric hospital in Wichita, KS; mental health center in Hays, KS; and general acute-care hospital in Joplin, MO. Wichita and Hays positions offer competitive salary and excellent fringe benefit package. Joplin position offers gross guaranteed income to establish private practice. If interested, contact Sarah Etzkin or Jeanne Reed at The Pickering Group, Inc., 11433 North Port Washington Road, Mequon, WI 53092; phone: 800-752-2464; fax: 414-241-8579.

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QUALITY OPPORTUNITIES for Primary Care and Surgical specialists in Arizona and throughout the U.S. Urgent needs for FP/IM, Peds, OB/GYN, Ortho, ENT, and General Surgeons. All inquiries confidential. Mitchell & Associates, Inc., P.O. Box 1804, Scottsdale, AZ 85252; 602-990-8080.

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Nitroglycerine Tolerance

DONALD L. VINE, M.D., *Wichita*

If constant exposure to nitroglycerine leads to attenuation of the vascular effects and to the development of tolerance, the clinician needs to know how long a single dose lasts and the duration of the nitrate-free interval needed to restore nitrate responsiveness.

Duration of Action

Zimrin and coworkers¹ infused nitroglycerine at rates of 20 to 120 $\mu\text{g}/\text{min}$ for 24 hours in 10 patients with chronic stable angina. The mean blood levels achieved (5.5–7.5 ng/ml) were two to three times those achieved with sublingual administration and 50 times the levels obtained with 5 mg patches. Bicycle stress tests were performed at baseline, one, four, eight, twelve and twenty-four hours. At 25 hours, sublingual nitroglycerine was given and bicycle testing repeated. An identical regimen was performed during placebo infusion.

Significant differences were found in exercise duration following treatment with nitroglycerine at one, four and eight hours after onset of infusion, but not at twenty-four hours (Figure 1). In

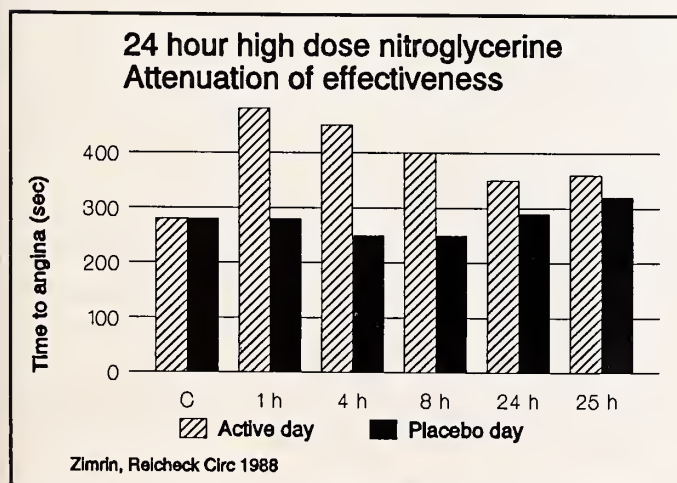


Figure 1. Duration of action of high-dose intravenous nitroglycerine.

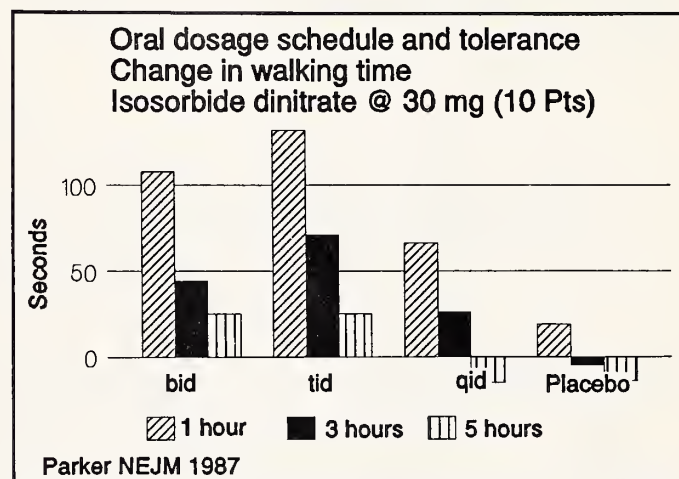


Figure 2. Change in exercise time after isosorbide dosages of 30 mg.

addition, the responsiveness to sublingual nitroglycerine, as measured by time to onset of angina, vanished following 24 hours of intravenous administration.

These observations are supported by the meta-analysis of randomized transdermal nitroglycerine trials reported by Colditz et al.² There was a statistically significant improvement in exercise tolerance for trials performing exercise tests at three to four hours following patch administration, but not for trials evaluating exercise after 24 hours.

Hemodynamic effects of nitroglycerine may last longer than the anti-anginal effects, but attenuation of lowered right atrial, pulmonary artery and capillary wedge pressures also begins within 24 hours among patients with congestive heart failure.³

Dosing Schedules

Parker and associates⁴ assigned 10 patients to a randomized series of isosorbide dinitrate dosage schedules of 30 mg twice, three and four times daily for periods of one week. Treadmill exercise to angina was performed at baseline and at one, three and five hours after the final dose. A sustained beneficial effect was observed for twice- and three-times-daily dosage schedules, but not for patients receiving four doses (Figure 2).

*Associate Professor, Department of Medicine, University of Kansas School of Medicine-Wichita

Address correspondence to Dr. Vine, Department of Medicine, UKSM-W, 1010 N. Kansas, Wichita, KS 67214.

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When long-acting isosorbide dinitrate is used, an asymmetric dosage schedule is best. Silber et al. found exercise-associated improvement in left ventricular ejection fraction to persist after two weeks of 80 mg of isosorbide dinitrate given at 8 a.m. and 2 p.m., but not when given at 8 a.m. and 8 p.m.

The nitrate-free interval required for continued responsiveness to the anti-anginal effects of transdermal nitroglycerine patches has been shown to vary from eight to twelve hours.^{5,6}

Comments

When nitroglycerine is given continuously, attenuation develops to the hemodynamic and anti-anginal effects in patients with angina or congestive failure. While there is wide variation in individual patient susceptibility to the development of tolerance, as little as 24 hours of continuous administration can lead to marked reduction or elimination of nitroglycerine effectiveness.

If intravenous nitroglycerine is used for the treatment of unstable angina, the therapeutic strategy should probably include the addition of a second anti-anginal agent and plans for transition to intermittent therapy by 18 to 24 hours.

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4. Parker JO, Farrell B, Lahey KA, et al. Effect of intervals between doses on the development of tolerance to isosorbide dinitrate. *N Engl J Med* 1987;316:1440-44.
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Notes & Quotes

NEWS FOR AND ABOUT KMS MEMBERS

JUNE 1991

AMA Physicians Recognition Award Changes Delayed

The AMA revised the PRA to require 60 hours of Category II credit every three years, in addition to Category I, and eliminated any credit for reading. This has caused much concern and confusion among physicians who are due to submit their CME requirements for relicensure on July 1, 1991.

The AMA has had difficulty in rewriting the PRA informational brochure describing the new requirements. Therefore, the AMA has decided not to implement the new requirements until January 1, 1992. Physicians applying for the PRA may continue to do so under the original requirements.

The KMS House of Delegates adopted a resolution requesting the AMA to reconsider its actions on the PRA and go back to the original requirements. This resolution will be considered by the AMA House of Delegates at the June meeting.

Two Doses of MMR Vaccine Required for School Entry

The Kansas Department of Health and Environment (KDHE) is requiring that all children who enter kindergarten (or first grade if they did not enter kindergarten during the previous year) in school year 1991-92 have proof of receiving two doses of combined measles, mumps and rubella (MMR) vaccine. Some physicians hesitate to give the second dose of MMR vaccine at school entry, primarily because of a belief that the children may be unprotected against measles in later years because of waning immunity.

The Immunization Practices Advisory Committee (ACIP) and the American Academy of Pediatrics (AAP) state the evidence for waning immunity is small. They report that most cases of measles in previously vaccinated children are probably due to primary vaccine failure. The primary failure may have been the result of the vaccine being given too early (i.e., 12-14 months of age), or the vaccine not having been shipped, stored or administered properly. The lability of the measles vaccine before a new stabilizer was added in 1979 could have contributed to vaccine failure in children or adults vaccinated before 1980.

Since waning immunity is not a major reason for measles disease in previously vaccinated children, KDHE is requiring children to receive the second dose of MMR vaccine at school entry primarily for practical reasons. Children receive other vaccines at this time; therefore an additional provider visit for the second dose of measles vaccine is not necessary.

American Lung Association Offers Awards and Grants

Seven different awards and grants are being offered to qualified physicians by the American Lung Association to further the conquest of lung disease, the pro-

motion of lung health and the development of academic scientists. To obtain specific information and application forms, write: American Lung Association, Medical Affairs Division, 1740 Broadway, New York, NY 10019-4374.

NIH Conferences to Be Held This Summer

Two summer conferences will be sponsored by the National Institutes of Health and held in Bethesda, Maryland. Effects and Side Effects of Dental Restorative Materials will be held August 26-28, 1991, and The Treatment of Panic Disorder on September 25-27. To register for either conference, call the Conference Registrar, Prospect Associates, 301-468-MEET.

Congratulations

...To Rex R. Fischer, M.D., Manhattan, who has been elected to a second consecutive one-year term as chairman of the 17-member Blue Cross and Blue Shield Board of Directors. Kent E. Palmberg, M.D., Topeka, also continues to serve on the board.

...To G. William Nice, M.D., Topeka, who received the 1991 Cardinal Citation from Labette Community College at their commencement ceremonies this spring.

...To the KMS Auxiliary for achieving 75% or more unified membership with the AMA Auxiliary. The Kansas auxiliary was recognized for this achievement at the annual session of the AMAA.

Help Is On the Way!

What do CPT guides, medical manuals, texts and dictionaries, computer software, retirement planning publications, miscellaneous kits and handbooks, mugs, glasses, pens, clocks, bookends, videos and golf instructional programs have in common? All are found in the Summer 1991 Catalog of AMA Publications, Products and Services. For a copy, call toll-free, 800-621-8335.

They've Got Your Patients Covered

A new type of medical coverage is now offered by a La Jolla, California company. No, it's not insurance, but it does insure that hospitalized patients will suffer from less embarrassment during their stay. The No Moon Company offers a hospital gown that securely covers a patient's backside with an overlapping flap that closes with Velcro tabs instead of ties. The gown costs three times what standard gowns sell for, but the "bottom line" may justify the expense!

Dates to Remember

Several lesser summer observances are just too good to miss. Mark your calendar now for National Anti-Boredom Month (July); Dog Days, July 3 through August 15 (as if we needed to be reminded!); National Cheer Up the Lonely Day (July 11); National Clown Week (August 1-7); Army Nurses Pay Raise Anniversary (August 3); National Smile Week (August 5-11); and National Relaxation Day, August 15 (don't forget that one!).

In a more serious vein, July 28 through August 3 is Nuclear Medicine Week, and August 4 through 10 is National Certified Nurse Anesthetist Week. Observe and enjoy them all!

KANSAS MEDICINE

JOURNAL OF THE KANSAS MEDICAL SOCIETY

July 1991

Volume 92, Number 7

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Carotid Endarterectomy
Blue Cross Contracts



KANSAS MEDICINE

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**ABOUT OUR LOGO**

In January 1935, a new logo appeared on the cover of KANSAS MEDICINE for the first time. This device represents two stethoscopes: the original monaural type as used by Laënnec, and the modern binaural variety. The logo was designed expressly for KANSAS MEDICINE by renowned graphic designer Bradbury Thompson, a native of Topeka and friend of two former editors of the journal, Dr. W.M. Mills and Dr. Lucien Pyle. As another former editor, Dr. Orville R. Clark, wrote in January 1955, the logo "has become as much a part of the journal as any of the features on the inside and is something which is ours alone."

P*inciples and Practice of Barn Construction* 101 continues. The subject is round (or, as etymologists would have it, circular) barns. The beauty of such structures is enhanced in Jim Hamil's rendition of one near Fort Scott. That it can be pleasing to the eye demonstrates that the utilitarian need not sacrifice that beauty and, indeed, there seems little evidence in the history of these structures to account for such form other than eye pleasure. True, engineers will tell us that the circular form provides the greatest interior space in relation to the exterior walls of any of the many shapes barns have taken.

The circular design in general does go back to antiquity, born perhaps from the tribe sitting around the central fire. Even so, its adaptation to barns is relatively modern in that, in this country at least, the first quarter of the 19th century seems to have marked their first appearance. Their development mingles with that of various polygonal forms that have been tried. (After all, if you keep increasing the "-gons," you eventually wind up with points which thereby make a circle.) The humanists of that century contributed as they sought various forms of homes to enhance living relationships. James Madison and Thomas Jefferson made use of the octagon in their designs, and Orson Fowler's octagon house was an example. (*Fowler on Matrimony* was one of the early "sex" manuals, but whether octagons had anything to do with that is not clear.)

As for barns, however, it seems to have been the Shakers who gave this form more attention than others, and here religion enters in since it has long been known that the circular structures gave the Devil no corners to hide in.

Although the exteriors are pleasing, the interiors have their own beauty. The complexities of design, the compound angles and imagination which went into providing the hay mow, storage for other crops and space for animals resulted in an efficient utility as compelling as the more evidently artistic exterior.

Perhaps, however, the infrequency of the full circle as compared to the polygons has been a practical matter. Round barns had to be of such a size that the planks or clapboards used for the walls could accommodate to the necessary curvature. Still, if they had been easily built and frequently seen, we probably wouldn't find them so attractive.

Mind Reading for the 90s

For more than three years now, the matter has moved at the usual judicial pace through various stages of appeal. It involves the Texas obstetrician who deemed it necessary to transfer a patient (who was in what he interpreted as desultory labor) to an installation some 170 miles away. It was his judgment that the patient (of whom he had no prior acquaintance) presented potential complications which warranted the transfer to a center with more sophisticated facilities. As obstetrical patients will on occasion, the patient delivered without incident — other than the fact that it occurred when she was only 40 miles into the trip.



The action against the physician, therefore, is not based on an unhappy obstetrical outcome but primarily on whether he was guilty of that behavior which causes the minions of governmental regulations to prick up their ears: “patient dumping” (or, as you need not be told, sending an indigent patient to another facility simply to avoid the economic burden of his or her care).

At this point, we are advised, the effort will be to determine the physician’s intent in authorizing the transfer. Undoubtedly, there are volumes of legal opinion seeking to interpret, define and apply the doctrine of intent. But it seems to us a particularly knotty problem, not easily solved in an individual case by the volume of decisions in others. It requires a dissection of the subject’s mind, sorting through his or her principles and philosophies, holding them up to the light and determining whether they were good or bad. And most of all, interpretation requires not only putting ourselves into the mind of the individual but assessing long after the fact those findings as they applied to particular circumstances.

We have no particular brief for the physician involved other than some acquaintance with the manner in which pregnant women can confound the best intentions of those benighted individuals, the obstetricians. We doubt that any physician approaches a given patient with prior evil intent in the management of that patient. It is a matter of personal and professional pride, governmental pressures, financial benefit and overall survival to perform to the best of one’s abilities. We don’t

know what the physician’s original intent was — and, at this point, wonder if *he* does, since his defenses over the years must surely have solidified a self-supportive determination.

But, for the most part, we physicians go along and our intents are absorbed into our efforts and results — unless challenged (as they have been with increasing frequency in the last few decades). It is usually when challenged that the fragile nature of intent becomes apparent. Any small boy learns this as early as he commits some offense calling for confrontation with the Voice of Authority. He finds that one way to survive is to adjust “intent” to a form acceptable to the dictates of that VOA. So it is when matters of greater importance (in the opinion of the adult world) occur. Intent gains prominence as it becomes the focus for judgment by one or another of the judging entities.

The case cited, however, points up a somewhat different facet of intent. As we mentioned, the issue is only tangentially related to obstetrical acumen. The intent may have been medical, but the resulting contention originated in social economics. It became the concern of governmental health care regulations and remuneration, the government’s determination of the methods by which medical care should be provided to a given segment of the population. Although the matter has moved into the courts (the circuit court in this instance), it was the Department of Health and Human Resources that brought — and decided — the earlier actions.

Although it is generally used without serious consideration of the concept, intent is a form of applied ethics. It embodies that code of behavior which should be capable of withstanding, under challenge, the scrutiny of the principles from which it is formed. This, however, implies durability and constancy. Intent is, in fact, insubstantial, requiring an objective to become effective. Thus, the court will presumably be using the legalistic interpretation, measuring the matter through the means (the physician’s action), the method (transferring the patient), and the effect (in the light of regulations) to arrive back at the objective, the basis of the physician’s intent.

It will be decided — but will it be settled? **D.E.G.**

Tell us where it hurts.

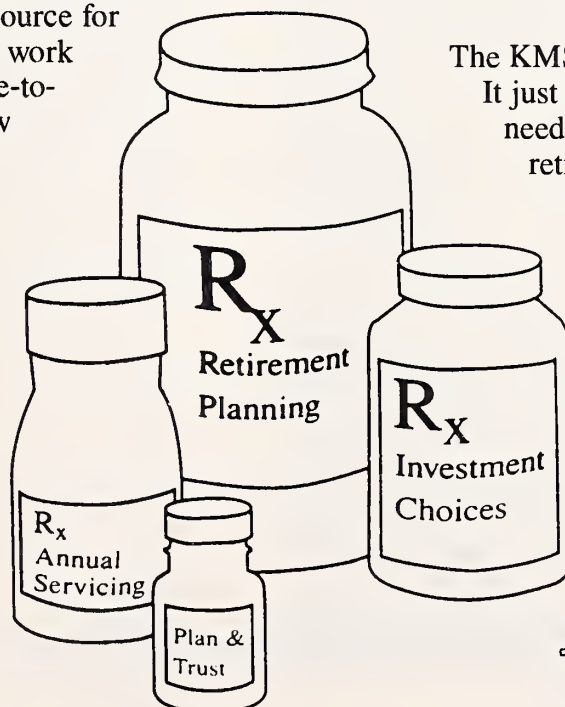
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To Arms, To Arms

In the June 26, 1991 issue of *JAMA*, James S. Todd, M.D., Executive Vice President of the AMA, predicted that physician payment reform and the issue in which it is embedded (the rising cost of medical care) and the question of testing of physicians and patients for the AIDS virus would be dominant issues at the Chicago meeting of the American Medical Association. Having just returned from that AMA meeting, I can attest to the fact that Dr. Todd accurately predicted the key issues. In regard to the AIDS issue, I personally support testing of patients without required informed consent and mandatory testing of physicians and other health care workers who are involved in invasive health care services. I can, however, understand and support the final AMA resolutions on HIV testing to treat this infection as any other contagious illness, but not go as far in identification of infected individuals as I would like to see.



In that same *JAMA* issue, Dr. Todd further stated: "The medical profession is at a crossroads. On the one hand, we can reach out to the public on these key issues and achieve greatness. On the other, we can be destroyed by the vested interests within medicine." Although the general feeling at this meeting was one of frustration and betrayal following recent HCFA statements on Medicare reimbursement for physician services, I am proud to report that the AMA again took the high road and continues to stand firmly united and committed to physician payment reform which will address problems in access to health care that have been aggravated by two decades of inequitable physician payment in regard to cognitive versus procedural services. The high road of professionalism was further supported by the inaugural speech of our new AMA President, John J. Ring, M.D. Dr. Ring challenged us as he asked the questions "Are we entrepreneurs or healers of the sick?" and "Are we professionals with business incidental, or are we businessmen with incidental professionalism?" He urged us to consider "Beneficence to patients as our litmus test."

Since the inception of the Harvard study on the Resource-Based Relative Value Scale, the

American Medical Association has worked in cooperation with and, in fact, provided financial support to assist and enlarge this initial research effort toward a rational approach to the reform of physician reimbursement. The RBRVS was first published in the fall of 1988 and has been further refined to the point that federal legislation has been passed to accept the RBRVS as a guide for physician payment reform with legislative instruction that this schedule be used in a *budget-neutral* manner. In other words, the legislative intent was that the same total number of dollars will be provided to physicians for Medicare services, but those dollars would be to some extent shifted from procedural to cognitive services. The recent physician reimbursement schedule presented by HCFA has introduced new terms with a 3% "behavior offset," a 2% "transition adjustment due to asymmetry" and a 16% reduction in the "conversion factor," which will reduce total physician reimbursement by billions of dollars and goes beyond the intent of the original federal legislation.

You have by now seen articles in various lay and medical publications including the *American Medical News*, describing "behavioral offset," "transition asymmetry" and the "conversion factor." A special mailing from the KMS office has advised you that without legislative action or massive public comment, these proposed HCFA changes will be implemented later this year. Because of this small window of opportunity, we must quickly enlist our patients to join us as we contact our federal representatives to encourage the development of legislation that will force HCFA to implement RBRVS in a budget-neutral manner. We should further ask our representatives to personally contact Gail Wilensky, Ph.D., of HCFA; Louis Sullivan, M.D., HHS Secretary; and Richard Darman, OMB Director. Their addresses are printed on page 202. Our request should be simple, direct and specific to correct the conversion factor so that the Resource-Based Relative Value Scale can be used in a budget-neutral manner to foster access to health care.

Although as physicians we receive a smaller percentage of the health care dollar than we did 20 years ago, we must admit to the fact that we con-

(Continued on page 202.)

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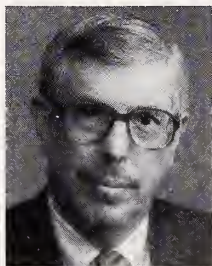
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Two New Decisions on Two Old Concepts

WAYNE T. STRATTON, J.D.,* *Topeka*

The Kansas Supreme Court decided two cases on May 24, 1991, which may have significant implications to Kansas physicians and other health care providers.



I. *Bair v. Peck*. In the *Bair* case, the 1986 amendment to the Health Care Provider Insurance Availability Act was challenged as unconstitutional. This amendment provided that:

(h) a health care provider who is qualified for coverage under the fund shall have no vicarious liability or responsibility for any injury or death arising out of the rendering of or the failure to render professional services inside or outside this state by any other health care provider who is also qualified for coverage under the fund. The provisions of this subsection shall apply to all claims filed on or after the effective date of this act.

The act was passed at the height of the mid-80s crisis in the cost of health care. It arose at a time when the Fund and insurance carriers were litigating claims that a corporate employer was responsible for the acts and conduct of physician employees, thus seeking contribution and indemnification. Frequently, a plaintiff would sue both the corporate employer and the employee for the same negligent act performed by the employee. The result was that health care providers were paying twice for essentially the same coverage.

In applying the traditional constitutional tests, the majority of the court concluded that the act did not limit the jury's right to determine the full amount of damages due an injured malpractice

Vicarious liability and the corporate practice of medicine.

plaintiff, nor did it limit the jury's right to assess the full amount of such damage against the actual tortfeasor. The statute did not deprive the plaintiff of the constitutional right to a trial by jury and did not violate the Bill of Rights of the Kansas Constitution.

As has occurred previously, the court split 4-3, with the minority composed of Justices Herd, Lockett and Allegrucci. Their position is that the legislation ignored the required *quid pro quo* as a substitute for a "remedy by due course of law." They consider the decision as a further retreat from established constitutional principles.

II. *Early Detection Center, Inc. v. Wilson, et al.* In the *Early Detection Center* case, the court was presented with a situation in which two physicians sold a portion of their interest in a professional corporation to two laymen, and the professional corporation converted to a general corporation. A dispute between a physician-stockholder and the corporation led to litigation. The physician was granted summary judgment by the trial court, which decision was upheld by the Kansas Supreme Court.

In deciding the case, the court came down strongly upon the previously decided ban on the corporate practice of medicine. The court reasoned:

1. Kansas statutes allowed physicians, surgeons, or doctors of medicine to form professional corporations to provide medical services. Both the person and the professional corporation must be licensed, by the terms of the law.

2. A professional corporation may only issue shares of its stock to a "qualified person." A "qualified person" under the

(Continued on page 192.)

*KMS Legal Counsel.

Comments appearing herein are not intended as a substitute for legal analysis or advice. Answers to legal questions depend largely upon the particular facts of a case. The reader is urged to consult an attorney for answers to specific legal questions.

These comments do not necessarily represent the views of KANSAS MEDICINE, or the Kansas Medical Society. For further information, contact Mr. Stratton, 515 S. Kansas, Topeka, KS 66603, 1-800-332-0248.



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professional corporation act is any natural person licensed to practice the same type of profession which any professional corporation is authorized to practice.

3. The professional corporation act does not authorize the practice of medicine by a general corporation or allow a general corporation to provide professional services under the supervision of a licensed practitioner.

4. A general corporation is prohibited from providing medical services or acting through licensed practitioners; therefore, there can be no contract between the general corporation and third parties to perform medical services.

5. Where parties enter into an agreement that cannot be enforced, the courts will not aid either party to the prohibited contract and will ordinarily leave the parties where it finds them.

It is not uncommon in recent years for hospitals to employ physicians or own clinics employing physicians. A literal application of the decision to such arrangements could result in a number of legal proceedings, including attempts to set aside contracts or to oppose the enforcement of contracts between physicians and general corporations. There is also a potential for a challenge to the corporate structure by the Attorney General. Thrown in doubt is the validity of buy-out contracts and restrictive covenant agreements between general corporations and employed physicians.

Professional corporations which may have converted to general corporations face the same potential challenges. Moreover, the court made it clear that the obligation to comply with the Health Care Stabilization Fund requirements is integral to the professional corporation, and is not permitted of general corporations.

Physicians participating in such arrangements should immediately reexamine them in light of this decision.

BLUE CROSS/BLUE SHIELD CONTRACTS Caveat Doctor!

Topeka BC/BS has mailed new physician contracts to primary care physicians who participate in their managed care programs, HMO Kansas and Blue Select. According to these contracts, BC/BS will establish expenditure targets (ETs), in the form of a range, every six months. There are several geographic "program areas" across the state. If the "program area costs" are *at or below* the ET, BC/BS will pay MAP allowance for the ensuing six months. But if the program area costs are *above* the ET, payments will be decreased by a percentage of the overage, up to a maximum of 10%. Reductions will not be made until *January 1, 1993*.

Office visits; immunizations and injections; and infant, child and adolescent care are *not* subject to MAP reductions and will be paid up to 100% of the MAP allowance. (If you bill less than the MAP allowance, you will be paid less.)

Incentives for primary care physicians who contract for the managed care programs have also changed. Individual costs per member per month will be calculated every six months and arrayed from low to high by primary care specialty and program area. Those physicians whose expenditures fall in the lower 70% will be eligible for an incentive *based on their ranking and the total program area performance*. Quality-of-care criteria must also be met in order to qualify for an incentive payment.

Please read your contracts carefully.

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Managed care contracts are out now. Regular BC/BS contracts are being mailed this month. *Please read these very carefully.* Call your BC/BS representative if you have *any* questions regarding these contract changes.

(See the "Notes & Quotes" column on page 203 for more Blue Cross/Blue Shield news. — Editor)

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Reducing Vaccination Barriers in Kansas

JOHN P. SCOTT* AND LINDA PERRY†

In 1989, Kansas had 142 reported cases of measles, and in 1990 the state had 235 cases of measles, including one death. By way of contrast, Kansas had no reported cases of measles in 1988.

This increase in the number of measles cases in Kansas mirrors the resurgence of the disease in the United States. During 1989, more than 18,000 measles cases were reported in this country. This is more than ten times the 1,497 cases of measles reported in 1987, the all-time low number of cases. There were also 41 deaths due to measles reported in 1989, the largest annual number of reported deaths in almost two decades. In 1990, more than 25,000 cases of measles were reported, with over 60 deaths. Almost half the cases occurred in unvaccinated preschool-aged children.

The recently issued paper by the National Vaccine Advisory Committee entitled "The Measles Epidemic: The Problems, Barriers and Recommendations" stated, "The principal cause for the epidemic is the failure to deliver vaccine to vulnerable preschool-age children on schedule. Major reasons for the low vaccine coverage exist within the health care system itself, which creates barriers to obtaining vaccination and fails to take advantage of many opportunities to provide vaccines to children when such children make health care visits. Many of the barriers result from policies which require advance appointments rather than providing immunization on request, and policies that require comprehensive physician evaluations, when appointments for such evaluations may take weeks to months to obtain. Other barriers result from insufficient state and local resources resulting in inadequate nursing staff, clinic hours, and clinic locations. The measles epidemic is a warning flag about children's immunization status and the nation must respond to this deficiency."

Many health care providers in Kansas may feel

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the problems documented in the National Advisory Committee report are not relevant in Kansas. However, a 1989 retrospective survey found only 64.4% of Kansas children had completed their basic vaccinations, consisting of four doses of DTP, three doses of OPV, and one dose of combined measles, mumps and rubella (MMR) vaccine by two years of age.¹ A Healthy People Objective is for 90% of children to have completed their basic vaccination series by two years of age. Obviously, we must do more to increase the vaccination levels in Kansas children.

The Committee stated there are four key types of barriers to timely vaccination. They are: missed opportunities for administering vaccination; shortfalls in the health care delivery system with barriers to immunization; inadequate access to care; and incomplete public awareness and lack of public request for immunization.

The Kansas Department of Health and Environment (KDHE), Bureau of Disease Control, Immunization Section recommends that public and private health care providers in each county work together to eliminate the barriers to vaccination in their areas. We also recommend providers take the following actions to improve their vaccination services.

- Review the vaccination status of children who present with illness.
- Vaccinate children if they have no known contraindications and appear to be in good health. Physical examinations or measuring of temperatures should not be routine requirements for vaccination.
- Post a list of contraindications and non-contraindications, and have all providers who order or administer vaccinations become familiar with the list.
- Inform parents or guardians of the benefits, risks and contraindications of vaccination. (Providers may obtain from the KDHE copies of the Important Information Forms developed by the Centers for Disease Control that can be used to inform parents or guardians of the benefits and risks of vaccination.)
- Keep children up-to-date with their vaccinations by administering all needed vaccines simultaneously.
- Give the telephone number, location and immunization clinic hours of the local health department to parents and guardians of the children referred to the local health department. (This will help parents and guardians obtain vaccinations for their children.)

- Develop a reminder/recall system to notify the parents and guardians of incompletely vaccinated children of scheduled appointments.
- Regularly review the vaccination recommendations published by the Immunization Practices Advisory Committee (ACIP) and the American Academy of Pediatrics (AAP). Copies of the current ACIP recommendations are available through the Immunization Section office.

To prevent the spread of vaccine-preventable disease if it occurs, we request that health care providers report any suspected or confirmed cases of vaccine-preventable disease (e.g., measles, mumps, rubella or pertussis) *by telephone* immediately to their local health departments or the Bureau of Disease Control, (913) 296-5593. We also recommend that all health care providers have a system to identify and isolate patients who present with rash illness. Additionally, we suggest that all providers keep up-to-date with their vaccinations to protect themselves and their patients from vaccine-preventable disease.

The KDHE would appreciate suggestions on what the State of Kansas can do to improve the timely vaccination of preschool-age children in Kansas.

REFERENCE

1. A breakdown of percentages by county for the state of Kansas is available from the authors.

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Carotid Endarterectomy: Immediate Morbidity and Mortality in 337 Patients

ALEX D. AMMAR, M.D., AND JAMES J. HANOSH, M.D.,* *Wichita*

Carotid endarterectomy has become the most frequently performed vascular operation in the United States. Nonetheless, the procedure has recently been criticized not only because of improper indications, but also because of a supposedly excessive morbidity and mortality.^{1,2} Thus, the purpose of this study is to analyze further the safety of carotid endarterectomy and, secondarily, its efficacy in treating carotid territory symptoms.

Methods

Two hundred eighty-eight patients undergoing 337 carotid endarterectomies were prospectively followed from January 1983 to January 1987. There were 160 males and 128 females with ages ranging from 40 to 91 years and a mean age of 69.4 years. The usual risk factors for atherosclerosis were present in these patients: 213 hypertensives, 85 diabetics, 204 smokers, 159 with a previous history or EKG evidence of myocardial infarction. All patients underwent either conventional or digital subtraction arteriography. Patients with specific carotid territory symptoms (either transient ischemic attacks or resolved strokes), including contralateral extremity weakness, dysphasia or ipsilateral amaurosis fugax, who demonstrated significant irregularity (ulceration) or stenosis on arteriography, were operated upon. In addition, if the arteriograms demonstrated a stenosis that reduced the arterial diameter by 70% or more in an asymptomatic patient, operation was recommended. No patients in this particular series were refused operation because they were considered to be at too high a risk. All operations were performed by one surgeon (ADA) in two community hospitals in Wichita. Forty-nine staged bilateral operations were performed, and three re-do operations were done. Two hundred thirty-two operations (69%) were done for sympto-

matic patients, and the remainder were done on patients with asymptomatic but significant stenosis.

The procedures were accomplished using general anesthesia and standard surgical techniques. Intraluminal shunts were used if there was a previous history of an ischemic infarct, contralateral carotid occlusion, or internal carotid artery stump pressure less than 50 mm of mercury. Patching of the arteriotomy was not done routinely, but it was necessary in two of the three re-do operations and in two females with exceedingly small arteries.

All patients were monitored intraoperatively with continuous arterial pressure monitoring and were followed in intensive care for 12 to 48 hours postoperatively. The hospital stay ranged from one to eight days, with an average stay of 2.8 days.

Most of the symptomatic patients were taking antiplatelet medications preoperatively, and many of these patients continued to have symptoms (although the exact number is not known). All patients were started on aspirin, 325 mg daily, the day prior to operation. This was continued postoperatively indefinitely.

Two hundred forty-five patients were seen in the office one to three weeks after their operations and again six to eight weeks after surgery. The remainder were interviewed by phone by the primary surgeon.

Results

Of 337 patients, three experienced clinical and laboratory-confirmed myocardial infarctions, with two deaths. Five patients had clinical and CT-scan evidence of ischemic strokes, all on the ipsilateral side. Three strokes were major deficits; two were minor, but fixed, deficits. One mildly hypertensive patient who was operated upon three weeks after an ischemic infarct (symptoms lasting only 90 minutes) documented on CT scan and

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Address correspondence and reprint requests to Dr. Ammar at 818 N. Emporia, Suite 200, Wichita, KS 67214.

due to a pre-occlusive stenosis at the origin of the internal carotid artery, did well for 48 hours and subsequently developed a large hemorrhagic infarct demonstrated on repeat CT scan. This patient died eight days after surgery. Three patients developed transient ischemic attacks within 36 hours of operation. Two of these had two separate TIAs and were re-explored. They were found to have platelet aggregation, and both patients did well after the second operation. The other patient had one brief TIA and underwent a Duplex scan, which was normal. This patient also did well subsequently. Two patients required neck exploration for evacuation of a hematoma. One patient experienced superficial infection requiring drainage. Another patient developed dysphagia due to an extremely high dissection on the internal carotid artery requiring division of the posterior belly of the digastric muscle. This patient's symptoms resolved within five weeks. Twelve patients had transient weakness of the hypoglossal nerve attributed to traction. All patients undergoing bilateral operation were studied by means of indirect laryngoscopy between operations, and none were found to have vocal cord paresis. None of the symptomatic patients (excluding the five

strokes and three TIAs immediately following surgery) experienced any carotid territory symptoms during the first two months of follow-up.

Discussion

Carotid endarterectomy has recently experienced negative publicity. Nonetheless, based on our results and confirmed many times by experienced, well trained vascular surgeons, this operation can be performed safely,³⁻⁶ with a 0.9% mortality and 1.5% stroke rate in our experience. The other complications were not permanent and were generally minor. Furthermore, this operation undeniably contributes solely or in part to the elimination of ipsilateral hemispheric carotid territory symptoms in the immediate postoperative period.

An ongoing project is continuing with respect to the long-term benefit of carotid endarterectomy in preventing cerebral ischemic symptoms in both symptomatic and asymptomatic patients and, in particular, to establish (or refute) the role of operation in asymptomatic but significant stenosis.

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THE WAY IT WAS

(From the minutes of the Douglas County Medical Society, September 1, 1903. It can be noted that Dr. James Naismith was a listener at this meeting and was an active member of the Society. He was reported to have given a paper on physical education on one occasion which was to be published in the journal, but a search of the files has failed to disclose it. "Dr. Woodruff" is not further identified, nor is there any record of what those uncouth Harvard boys called the "Charley Horse." Incidentally, the typos are faithfully reproduced. — Editor)

Dr. J.H. Outland then talked to the Society about FOOT-BALL INJURIES. The most frequent injury, he said is sprained ankle; next, partial dislocation of the knee. The first time a player sprains his ankle, he is apt to be laid out of the game for two or three weeks — subsequent sprains, just as severe apparently, get well in two days. Best treatment is by strapping, covered by a rubber bandage.

Partial dislocation of the knee usually leaves a weakened joint. Dr. Outland has never seen one that was left weak, and liable to slip out at any time and drop the owner to the ground. The usual advise to such patients is to quit the game for the season, but they never follow it. Treated by strapping and covered by a cloth roller, not a rubber bandage. The strapping must not cover the popliteal space, and the leg shaved in preparation for it.

Another common complaint is "shin-soreness," due, probably to a subperiosteal inflammation. The patient cannot stand on his toes on account of the pain and has to run flat-footed like a duck. It usually takes a man out of the game for a week and then is well.

Broken noses and clavicles are common, and dislocated shoulders are occasionally seen, but the shoulders usually escape on account of being well protected by pads in the uniform. These injuries are nearly all received in tackling. Broken noses usually are treated on the field and recipients go on with the game. The result is almost always

good. Dr. Outland has had his own nose broken three times and shows a perfectly straight nose in spite of it. Foot-ball players get well quicker than others, repair being more rapid on account of their perfect physical condition, and this is seen in case of broken bones, which unite rapidly.

The general wear and tear of the game, aside from injury, is considerable and the loss of weight in Dr. Outland's own case has been seven pounds in two 35 halves. This is partly due to loss of water by perspiration and it takes two or three days to regain the weight one had before the game.

A soreness and stiffness of the muscles of the thigh is common. It is quite severe for the time being, but soon gets well. The Pennsylvania men call the condition "Charley Horse." Harvard men call it by a still less elegant name which will be omitted here.

Dr. Outland has never seen a hernia caused on the foot ball field and he knows of men with hernia retained by trusses who have played hard foot ball without trouble resulting.

Eye injuries are not common and Dr. Woodruff's story about having his eye knocked out of the socket so that it laid on his cheek and its replacement with no loss of function was off the same piece of goods as some of his other stories.

A peculiar result of blows on the ears is a plastic infiltration which permanently thickens and distorts the auricle.

Flat foot occasionally results from breaking down of the instep.

A common result of heavy falls and blows on the head is called "knocked daffy." In this condition the player goes on with the game, but with his memory entirely gone. This may last for some hours, but it is not serious and recovery is complete.

In spite of dangers of accidents, Dr. Outland considered the benefits derived offset them entirely. A foot ball player gains in strength and endurance, in quickness of body and intellect, in moral and physical courage, and is better fitted for his life work.

Sensitivity and Specificity of Thallium Stress Testing

DONALD L. VINE, M.D.,* *Wichita*

Thallium-201 scintigraphy has become an accepted test for the evaluation of patients with coronary artery disease. To better understand the accuracy and limitations of this examination, I strongly recommend a recent review by Kotler and Diamond.¹

The authors evaluated 122 major exercise thal-

lative test, was 84% and ranged from 92% for patients with stenoses involving three vessels to 78% for patients with single-vessel disease. This means that the test may be negative in as many as 22% of patients with single-vessel disease.

Dipyridamole testing is similar to standard exercise, and technical enhancements such as quan-

TABLE 1
SENSITIVITY AND SPECIFICITY OF THALLIUM-201

	<i>Studies</i>	<i>Patients</i>	<i>Normal</i>	<i>Sen</i>	<i>Spec</i>
Diagnosis of coronary artery disease					
One vessel	13			78%	
Two vessel	13			89%	
Three vessel	13			92%	
Any vessel	33	3258	1140	84%	87%
Technical variations of testing					
Dipyridamole	5	336	79	85%	82%
Quantitative	8	1092	247	90%	75%
Tomography	3	361	72	96%	83%
Accuracy among patients with inconclusive electrocardiogram					
Inadequate exercise	6	98	66	78%	85%
Uninterpretable	4	80	37	74%	89%
High risk anatomy	7	923	555	46%	73%
Predicting multivessel disease after myocardial infarction					
Thallium only	6	340	176	70%	88%
Exercise ECG only	6	329	173	62%	70%
Thal + ECG	4	222	125	81%	70%
Predicting adverse events after acute myocardial infarction					
Thallium	2	255	183	82%	62%
Exercise ECG	2	250	178	49%	75%

limum-201 scintigraphy studies which provided measurements of specificity and sensitivity. Their findings are summarized in the table.

The overall *sensitivity*, or likelihood that a patient with coronary artery disease will have a pos-

itive test, was 84% and ranged from 92% for patients with stenoses involving three vessels to 78% for patients with single-vessel disease. This means that the test may be negative in as many as 22% of patients with single-vessel disease.

Dipyridamole testing is similar to standard exercise, and technical enhancements such as quantitative measurements and tomography seem to enhance sensitivity at the expense of specificity. The sensitivities for the detection of high-risk anatomy (46%) and identification of coronary artery disease in patients with inadequate exercise (78%) or abnormal resting ECGs (74%) are disappointing.

The sensitivity for predicting the presence of multivessel disease following myocardial infarction (70%) is less than that for predicting adverse

*Associate Professor, Department of Medicine, University of Kansas School of Medicine-Wichita

Address correspondence to Dr. Vine, Department of Medicine, UKSM-W, 1010 N. Kansas, Wichita, KS 67214.

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events (82%). Both are superior to the exercise electrocardiogram alone, but the authors caution that the incremental value of thallium stress testing after the history and exercise electrocardiogram are known has not been adequately evaluated.

Thallium-201 scintigraphy is a screening test which is not recommended by the authors for the diagnosis of coronary artery disease in patients who have either a very low or a very high pretest probability of ischemic heart disease. It is therefore not considered a good test for screening asymptomatic patients without risk factors, nor for confirmation of the diagnosis among patients with a typical history and a strongly positive exercise ECG.

Thallium stress testing is generally considered to be indicated for the diagnostic evaluation of patients with an intermediate likelihood of coronary artery disease or resting ECG abnormalities which might obscure the interpretation of the exercise electrocardiogram.

REFERENCE

1. Kotler TS, Diamond GA. Exercise thallium-201 scintigraphy in the diagnosis and prognosis of coronary artery disease. *Ann Intern Med* 1990;113:684-702.

PRESIDENT'S MESSAGE

(Continued from page 188.)

trol the lion's share of expenditures for health care. Our profession is at this time facing massive changes in regard to physician reimbursement, access to health care and resource allocation of health care dollars which will affect our profession for the next several years, if not the next several decades.

Larry Anderson, MD

Send your letters to:

Gail Wilensky, Ph.D., Director
Health Care Financing Administration
Department of Health and Human Services
P.O. Box 26676
Baltimore, MD 21207

Louis W. Sullivan, M.D., Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Richard G. Darman, Director
Office of Management and Budget
Executive Office Building
725 17th Street, NW
Washington, DC 20503

Notes & Quotes

NEWS FOR AND ABOUT KMS MEMBERS

JULY 1991

AMA Adopts New Position on AIDS

At the AMA Annual Meeting in June, the AMA House of Delegates adopted a resolution supporting HIV testing of physicians, healthcare workers and students "in appropriate situations" and requested that the AMA study the issue and report at the December 1991 meeting on specific instances in which testing should be performed, frequency of testing, professional liability insurance issues and factors involving granting of privileges and credentialing as they relate to HIV testing. The House also adopted the position that HIV testing should be "consistent with testing for other infections and communicable diseases."

Lending support to the resolution was adoption of Report 00 of the Board of Trustees, which recommended that "hospitals, clinics and physicians may adopt routine HIV testing based on local circumstances," and that state medical associations encourage revision of state laws that restrict routine HIV testing programs. Report 00 also stressed the confidentiality of HIV testing and counseling, and it called for the AMA to develop a simplified consent form.

RBRVS: Your Help Is Needed

The second version of RBRVS presents a picture of HCFA decisions which substantially reduce physician reimbursement for Medicare services. The most all-encompassing problem is the proposed conversion factor (CF) of \$26.873. Payment calculations using this CF are 16% lower, on average, than they were under the September 4 model fee schedule. "Behavioral offsets" have been factored in, and the transition period payment methodology further decreases the CF. Please watch for the special notice from KMS requesting letters to your congressional delegation.

Medicare Toll-Free Numbers Discontinued

Blue Cross/Blue Shield of Kansas has discontinued their toll-free telephone lines for physicians, as of July 1, 1991. This action appears to be in reaction to a proposed funding cut to carriers and in response to a HCFA directive. KMS has formally requested reinstatement of the toll-free lines. Given the complexity of the new physician payment reform system, RBRVS, calls to carriers are expected to increase dramatically. The elimination of the toll-free lines will increase physicians' "per-patient" Medicare costs substantially starting in October. Therefore, your attendance at workshops and meetings to obtain new information and clarification is strongly encouraged.

News from the Food and Drug Administration

Surgitek, a division of Bristol-Myers Squibb, has voluntarily suspended shipment of its Meme and Replicon polyurethane foam-coated breast implants and requests

that physicians delay implanting these devices while the FDA continues to evaluate laboratory and risk assessment data on a possible link between polyurethane foam and cancer.

Fludarabine has been approved by the FDA for use in patients who are not responding to other treatments for chronic lymphocytic leukemia (CLL). In clinical trials involving patients refractory to standard therapy, 32 to 48% of treated patients showed positive responses, including complete remissions in 13% of those treated. Fludarabine is being marketed by Berlex Laboratories of Alameda, California, under the trade name Fludara.

Congratulations

...To William Crouch, M.D., Topeka, who received the Jefferson Award for special dedication to public service in a presentation at the U.S. Capitol on June 18. Dr. Crouch, a retired pediatrician, received the award from Sen. Bob Dole.

...And to Ronald L. Martin, M.D., Wichita, who has been certified with Added Qualification in Geriatric Psychiatry by the American Board of Psychiatry and Neurology. Dr. Martin is a member of the first group of psychiatrists to sit for examination in the subspecialty, which was recently accepted by the American Board of Medical Specialties (ABMS).

Kansas Medical Assistants Society Conducts Survey

The Kansas Medical Assistants Society (KMAS) is surveying medical assistants throughout Kansas to determine if the combined cost of local, state and national dues is an impediment to membership. Surveys have been sent to the offices of all physicians licensed to practice in Kansas. KMAS would appreciate hearing from all medical assistants in your office.

Workshop Is Planned for Medical Assistants

A workshop co-sponsored by KMS and the Kansas Medical Assistants Society (KMAS) will be held from 9:00 a.m. to 3:30 p.m. on August 22, 1991, at the Holidome in Hutchinson. Topics to be included are: "Stress-Related Illnesses and Chronic Fatigue Syndrome," "Balancing Work and Family," "Legislation, Including Worker's Compensation" (Chip Wheelen, M.P.A., KMS Director of Public Affairs), and "RBRVS" (Carolyn Counts, KMS Director of Health Care Finance). The luncheon speaker will be Joseph E. McMullen, M.D., of Hutchinson, who will discuss "Medical Experiences in Operation Desert Shield." CEUs will be given. The fee is \$50 for members and \$80 for non-members. Information may be obtained from JoAnn Mzhickteno of KMAS, at 291-8639. To register, complete the form below and return it to Val Braun at Kansas Medical Society, 1300 Topeka Avenue, Topeka, KS 66612.

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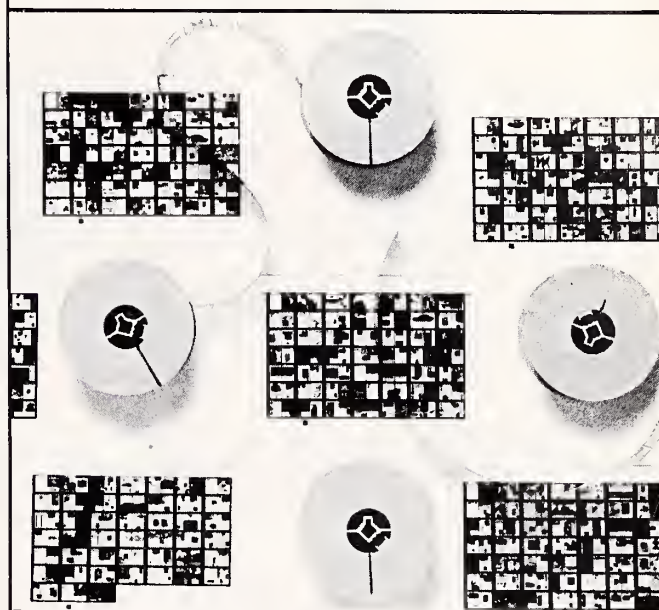
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In January 1935, a new logo appeared on the cover of KANSAS MEDICINE for the first time. This device represents two stethoscopes: the original monaural type as used by Laënnec, and the modern binaural variety. The logo was designed expressly for KANSAS MEDICINE by renowned graphic designer Bradbury Thompson, a native of Topeka and friend of two former editors of the journal, Dr. W.M. Mills and Dr. Lucien Pyle. As another former editor, Dr. Orville R. Clark, wrote in January 1955, the logo "has become as much a part of the journal as any of the features on the inside and is something which is ours alone."

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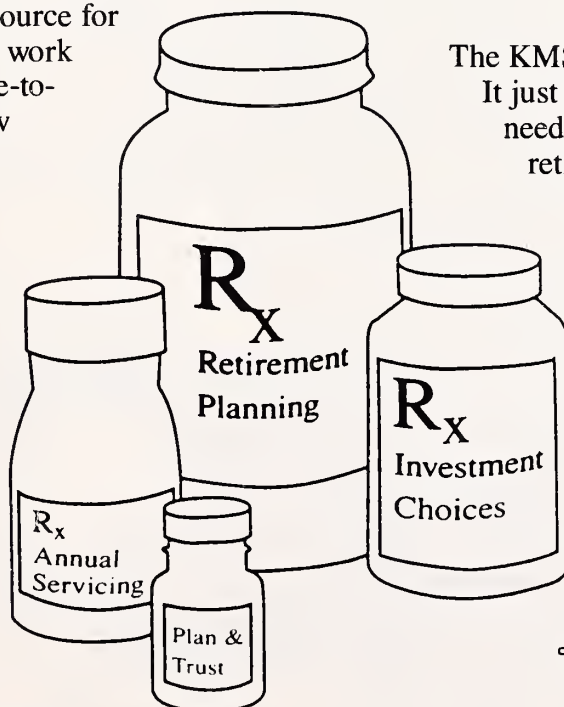
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Kansas Hospital Association 1263 SW Topeka, Topeka 66612	913-233-7436
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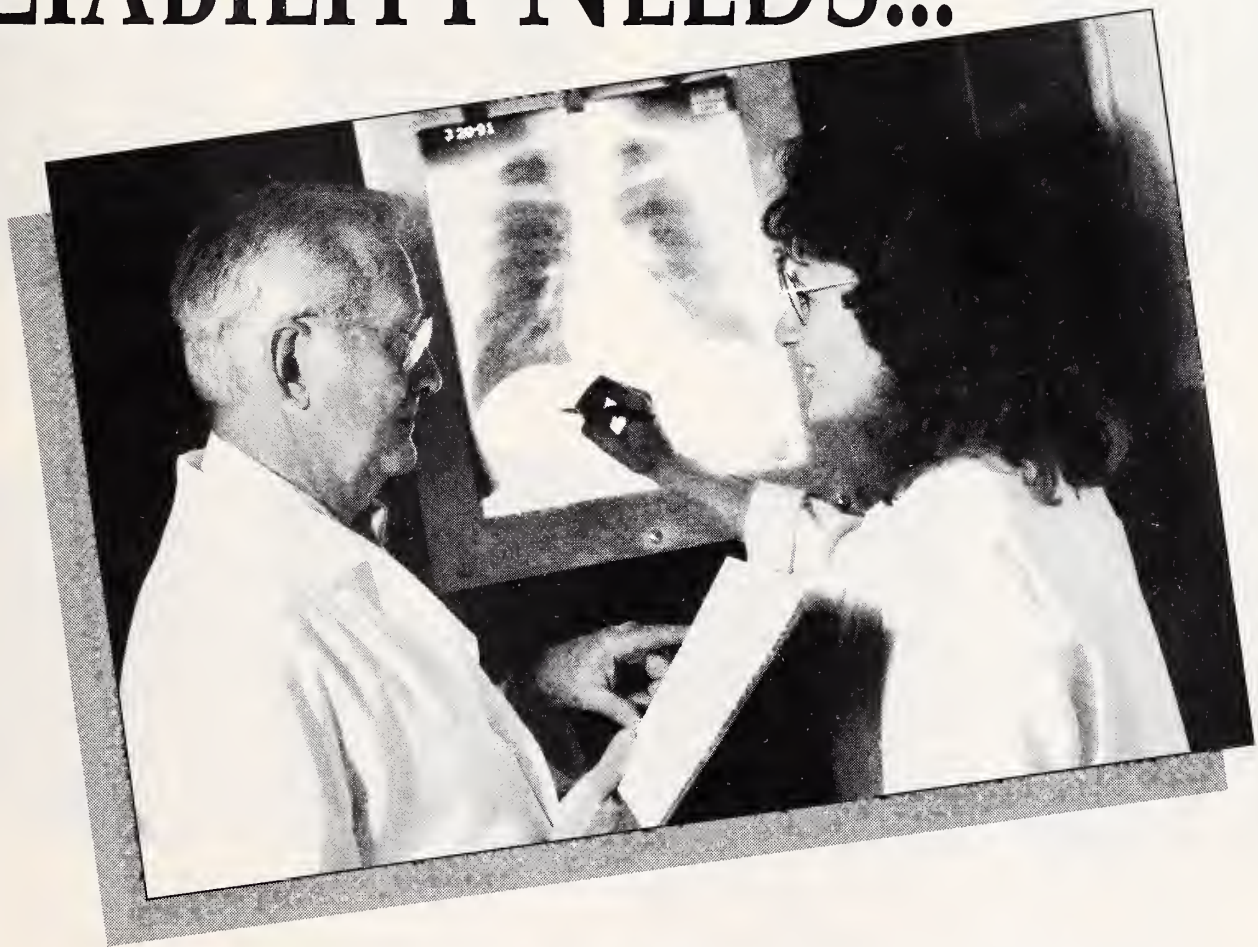
Statewide Handicapped Children's Services

A— Advocacy/support
Dx — Diagnosis
R — Referral

S — Screening
Tx — Treatment

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Department of Education	
Department of Health & Environment	
University of Kansas Affiliated Facilities	
Early Bird Project	
Personal Development Resource Systems	
Social & Rehabilitation Services	
EPSDT (S, R)	913-296-3981
Local health departments or SRS State Coordinator	
Kansas Neurological Institute (Dx, R)	913-296-5377
3107 W. 21st, Topeka KS 66604	
Services for Children with Special Health Care Needs (S, Dx, Tx)	913-296-1313
Regional Deaf-Blind Program (R)	913-296-2062
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KUMC-Kansas City	913-588-5926
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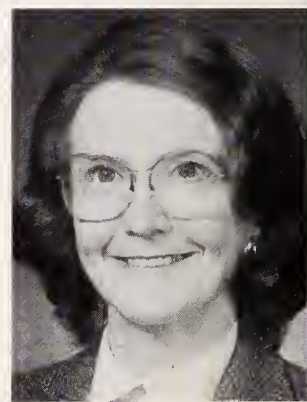
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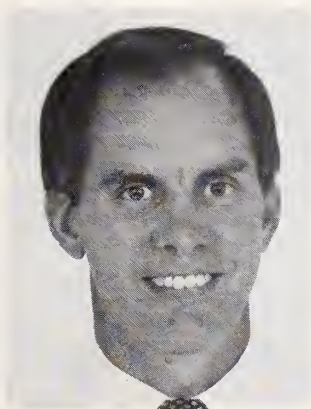
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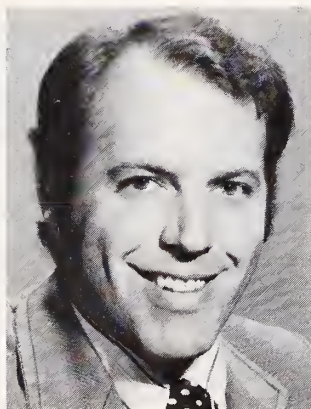
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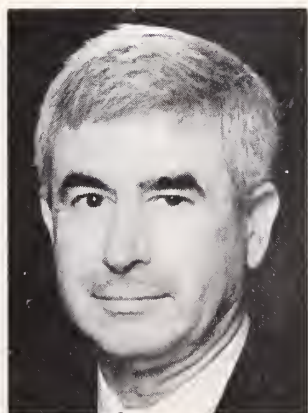
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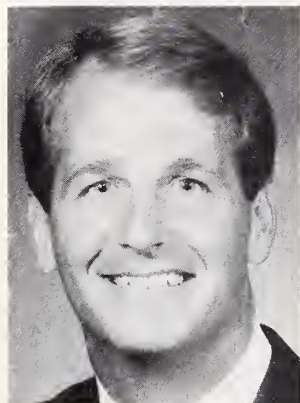


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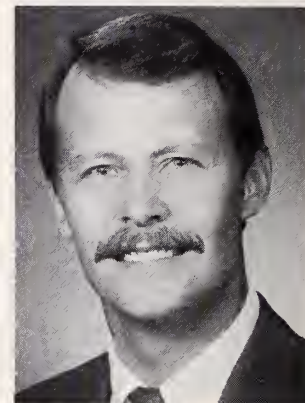
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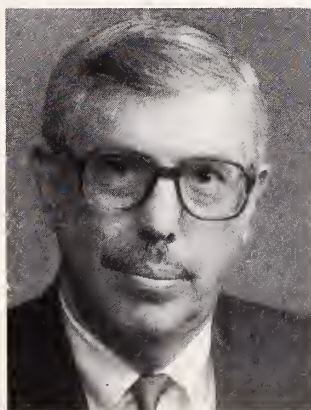
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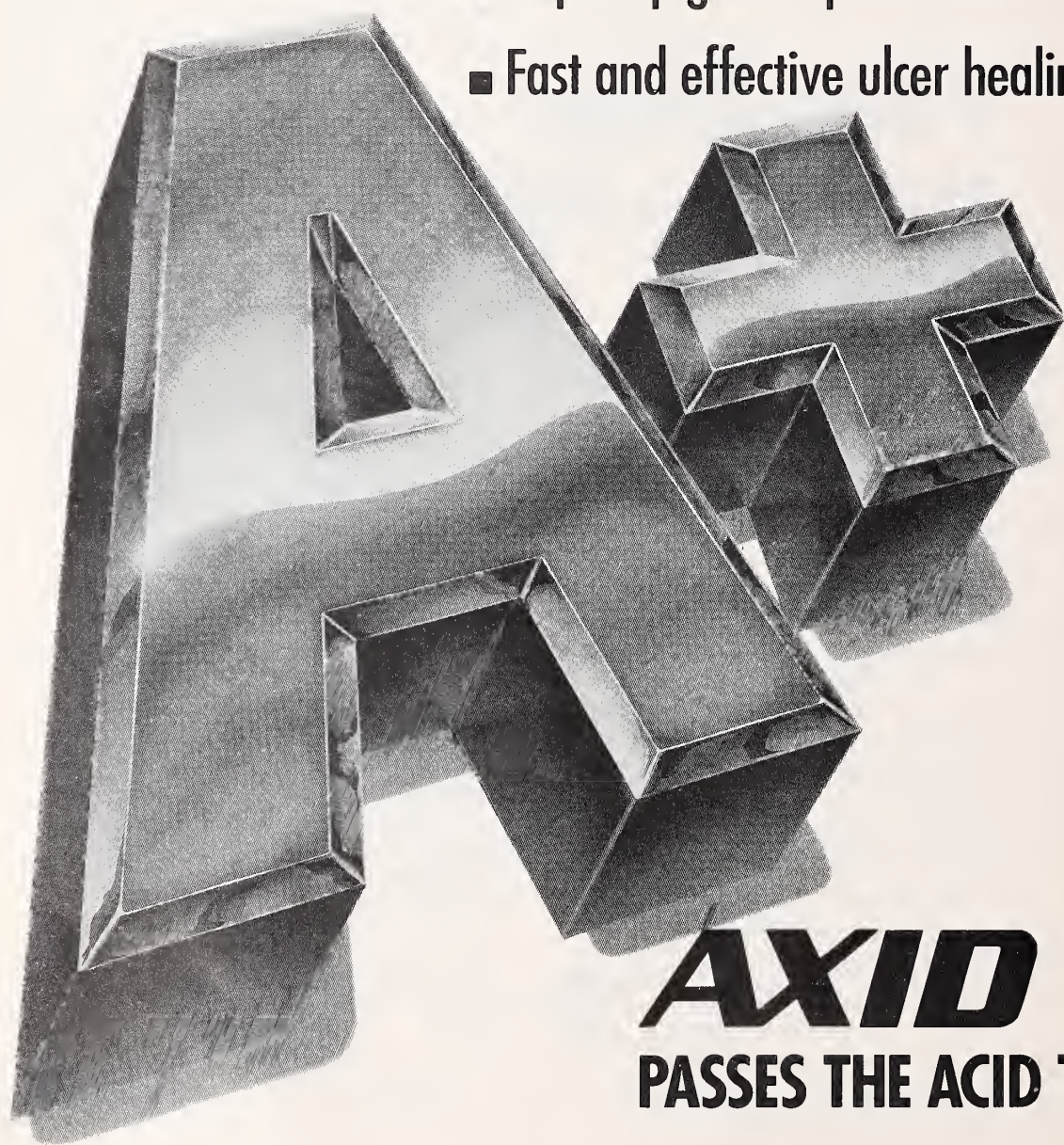
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Indications and Usage: 1. *Active duodenal ulcer*—for up to 8 weeks of treatment. Most patients heal within 4 weeks.

2. *Maintenance therapy*—for healed duodenal ulcer patients at a reduced dosage of 150 mg h.s. The consequences of therapy with Axid for longer than 1 year are not known.

Contraindications: Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H₂-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H₂-receptor antagonists.

Precautions: General—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix® may occur during therapy.

Drug Interactions—No interactions have been observed with theophylline, chloridazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events were due to the drug.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since marked introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H₂-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H₂-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis does not substantially increase clearance of nizatidine due to its large volume of distribution.

PV 2091 AMP
[091190]

References

1. Data on file, Lilly Research Laboratories.
 2. *Scand J Gastroenterol*. 1987;22(suppl 136):61-70.
 3. *Scand J Gastroenterol*. 1987;22(suppl 136):47-55.
 4. *Am J Gastroenterol*. 1989;84:769-774.
- NZ-2943-B-149347

Additional information available to the profession on request.



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WORKERS' COMPENSATION INSURANCE

Helpful Hints on Audit Procedures

At the expiration date of your policy year, an audit is made by the insurance company to determine the actual payroll amounts, or other exposures during the year. Following this audit, an adjustment may be made that will require additional premium, or a return or credit will be ordered. Following are five tips to assist you in preparing for an audit. These sources will help the auditor:

- Payroll journal providing monthly totals and division of payroll by type of work performed.
- Individual earning records indicating the type of work performed. Gross payroll should be totaled by the quarter.
- Separate record of overtime shown by employee and totaled by class of work for the policy term involved. (Premium for Workers' Compensation is based on straight time pay for all hours worked and does not include ½ extra pay for overtime.) (Not applicable in Delaware, Pennsylvania, and Utah.)
- Certificates of Workers' Compensation Insurance for all insured sub-contractors.
- Social Security (Form 941) and State Unemployment Compensation quarterly returns.

Auditors are instructed to inform you of the date they intend to call on you or to arrange in advance for a convenient time. To assure accurate assignment of your payroll in the proper classes, it is wise for you to arrange to have someone in your organization familiar with employee job assignments available to work with the auditor during the course of the audit.

If your records are kept by an outside accounting firm, make certain the accountants are aware of the impending visit by the auditor so they will have your records available when needed. In the event the accountant is not well informed regarding the duties of various employees, you may wish to brief him/her in advance of the auditor's visit.

In the audit of your payroll for final billing purposes, you need to determine that the payroll of individual employees is assigned to the appropriate rating classification. This assures that you will be paying the correct premium.

Annual premiums in excess of a specified amount qualify for a discount which varies by state and also by the amount of premium needed to be eligible for the discount. Contact your sales representative if you have any questions about discounts or classifications.

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NEW GUIDELINES HELP IN NUTRITION EDUCATION

Moderation and variety are the keys to the newly released *Dietary Guidelines for Americans* published by the USDA and the USDHHS. The seven guidelines are:

- Eat a variety of foods
- Maintain healthy weight
- Choose a diet low in fat, saturated fat, and cholesterol
- Choose a diet with plenty of vegetables, fruits, and grain products
- Use sugars only in moderation
- Use salt and sodium only in moderation
- If you drink alcoholic beverages, do so in moderation

Following these guidelines does not mean eliminating foods, but rather limiting some while increasing others.

Diets low in fat, saturated fat, and cholesterol include vegetables, fruits, and grain products, but can also include lean meats and low-fat dairy products. To have a nutritious and more enjoyable diet, eat a variety of foods. Moderate portions of trimmed lean cuts of beef, pork, lamb, and veal are excellent sources of protein, iron, zinc, and B vitamins.

For a copy of the new Dietary Guidelines, write to the Human Nutrition Information Service, USDA, Room 325-A, 6505 Belcrest Road, Hyattsville, MD 20782. You also can get more information on nutrition from this column. In future issues, we will be providing additional information to help you answer patient questions about diet and nutrition.

This column is brought to you by the National Live Stock and Meat Board, the Beef Promotion and Research Board, and the National Pork Board.

LEAN MEAT IN A HEART-HEALTHY DIET

Did you know that thanks to improved breeding and feeding practices as well as closer trimming by retailers, today's meat is leaner than in the past? You can enjoy lean meat in a heart-healthy diet by following a few simple guidelines:

SERVING SIZE

Keep moderate—3 ounces cooked—about the size of a deck of cards or the palm of a woman's hand.

LEAN CUTS

When shopping or ordering in a restaurant, look for leaner cuts. Remember beef cuts will be leaner if they contain the word "loin" or "round" in their name and pork cuts containing the word "loin" or "leg" are lean.

- ◆ Lean beef cuts: eye of round, top round, round tip, sirloin, top loin, and tenderloin
- ◆ Lean pork cuts: tenderloin, top loin, center loin, sirloin, boneless ham (90% to 95% lean), and Canadian bacon
- ◆ Lean veal cuts: sirloin, cutlet, and arm steak

PREPARATION

Use low-fat cooking methods

- ◆ Before cooking, trim all separable fat
- ◆ Broil, bake, and roast on a rack so that fat can drip away
- ◆ Use nonstick cooking spray rather than oil
- ◆ Separate fat from gravies, stews, and soups by chilling and skimming fat from the surface, or by using a gravy separator
- ◆ Avoid cooking methods like frying that add fat

This column is brought to you by the National Live Stock and Meat Board, the Beef Promotion and Research Board, and the National Pork Board.

DINING OUT WITH NUTRITION IN MIND

Many people find they can stick to a healthy eating plan if they eat at home, but dining out is another matter. Fortunately, many restaurants are becoming more health-conscious and offering low-fat dishes.

You can also make healthy dining choices by following these few simple guidelines:

- Ask for entrées that are broiled, roasted, baked, steamed, poached, or cooked in their own juices.
- Trim the fat off meats and the skin off chicken.
- When having meat, try to keep your portion to a 3-ounce serving size (about the size of a deck of cards). If portion sizes are too large, share your entrée with a friend or eat part of your entrée and take the rest home.
- Ask for sauces and salad dressings on the side and use them sparingly.
- Ask for vegetables to be steamed.
- Eat rolls, bread, and breadsticks without butter.
- Share a dessert with your dining partner.
- If you're not sure how a dish is prepared, don't hesitate to ask. Also ask if the chef can prepare your dish in a low-fat manner.

Restaurants offer lean cuts of meat under many names. Here is a quick reference guide for the leanest cuts to order:

BEEF TOP LOIN: Delmonico, Kansas City, New York, Strip Steak

BEEF TOP SIRLOIN: Top Butt, London Broil, Kabob, Sirloin Steak

BEEF TENDERLOIN: Chateaubriand, Filet Mignon, Kabob, Medallions, Tournedos

BEEF TOP ROUND: Kabob, London Broil, Beef Roast

BEEF EYE OF ROUND: Beef Roast or Steak

PORK TENDERLOIN: Medallions, Pork Tenderloin

PORK LOIN: America's Cut™, Butterfly Chop, Pork Chops, Pork Cutlet, Roast Pork Loin, Stir Fry

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- Overland Park** — Mid-America Rehabilitation, 5701 West 110th Street 66211 — 913/491-2400
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- Phillipsburg** — Phillips County, P.O. Box 607 67661 — 913/543-5226

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66534 — 913/284-2121

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67756 — 913/332-2104

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67576 — 316/549-3255

Salina — Asbury-Salina Regional Medical Center,
P.O. Box 5080 67402-5080 — 913/827-4411

Salina — St. John's, P.O. Box 5201 67402
— 913/827-5591

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Scott City — Scott County, 310 East Third 67871
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Center, 9100 West 74th Street 66201 —
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1500 West 10th 66604-1353 — 913/354-6000

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Box 338 67879 — 316/376-4221

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67880 — 316/356-1266

WaKeeney — Trego County-Lemke Memorial, 320
Thirteenth Street 67672 — 913/743-2182

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829 66601 — 913/273-7500

Topeka — Parkview, 3707 SW 6th 66606 — 913/
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67208 — 316/681-1800

Wichita — Charter Hospital-Wichita, 8901 E.
Orme 67207 — 316/686-5000

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66064 — 913/755-3151

Parsons — Parsons State Hospital & Training
Center, P.O. Box 738 67357 — 316/421-6550

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West 21st Street 66604-3298 — 913/296-5301

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Leavenworth — U.S. Penitentiary 66048 — 913/
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Wichita — HCA Wesley Medical Center — 316/688-
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— 316/686-2444

Anthony 67003

Harper County, Court House — 316/842-5264

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Rawlins County, 607 Main — 913/626-3968

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Baxter Memorial Hospital, 10th & Washington —
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North Central Kansas, 400 W. 8th, Box 217 —
913/738-5175

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Coffey County, Court House — 316/364-8631

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316/431-4000

Clay Center 67432
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Coffeyville 67337
Health Care Services/Montgomery County,
808 Willow, Box 586 — 316/251-7161
Montgomery County, City Building, 604 Union
Street — 316/251-4210

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Ellsworth County Court House —
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Shawnee Mission
Always Better Care, Inc., 10111 Santa Fe Drive 66212 — 913/888-4447
Home Health-Home Care, Inc., 8900 State Line, Suite 332 66206 — 913/341-8830
Medical Personnel Pool of Kansas City, 7600 State Line, Suite 200 66208 — 913/341-2181

Stockton 67669
Rooks County, Court House — 913/425-7352

Topeka
Topeka-Shawnee County, 1615 W. 8th 66606 — 913/233-8961

EXTRA COPIES

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To order, write or call Donna Decker at:

Kansas Medical Society
1300 Topeka Avenue
Topeka, KS 66612

913-235-2383, or 800-332-0156

Associated Healthfocus, 1925 SW 6th, 66604 — 913/232-1253

Troy 66087
Doniphan County, Court House, P.O. Box 201 — 913/985-3886

Ulysses 67880
Bob Wilson Memorial, 415 N. Main — 316/356-1266

Washington 66968
Washington County, 115 W. 3rd — 913/325-2600

Wellington 67152
Sumner County, Court House — 316/326-2774

Westmoreland 66549
Pottawatomie Cty., 320 Main — 913/457-3719

Wichita
Agency for Home Health Care of Kansas, 3333 E. Central, Suite 503 67208 — 316/681-1632
Kansas Masonic Home, 401 S. Seneca 67213 — 316/267-0271
Kimberly Quality Care, 434 N. Oliver 67208 — 316/687-3534
Medical Personnel Pool, 1035 Parklane 67218 — 316/686-3388
Professional Care Associates, 959 N. Emporia, Suite 303 67214 — 316/268-8588
Wesley Care, 550 N. Hillside 67214 — 316/688-7272
Wichita-Sedgwick County, 1900 E. 9th 67214 — 316/268-8433

Winfield 67156
William Newton Memorial Hospital, 1300 E. 5th — 316/221-2300

GENETIC COUNSELING CENTERS

Garden City — Genetic Outreach Clinic, Garden Medical Center, Call 316/688-2360 (Wichita)

Hays — Post Rock Pediatric Clinic — 913/628-6128, Ext. 29, or Kansas City Center

Kansas City — Department of Endocrinology, Division of Genetics, KUMC, 39th & Rainbow Blvd., Kansas City, KS 66103 — 913/588-6043, R. Neil Schimke, M.D., Director; Debra L. Collins, M.S., Genetic Counselor

Parsons — Parsons State Hospital & Training Center — 316/421-6550, Ex. 227, or Kansas City Center

Salina — Asbury-Salina Med. Center, 300 W. Ash, Room 107, 67401 — 913/827-9376, or Kansas City Center

Wichita — Genetic Clinic, Department of Pediatrics, UKSM-Wichita, 1010 N. Kansas, Wichita, 67214 — 316/261-2622

Wichita — Prenatal Diagnosis & Genetic Clinic, Division of Perinatal Medicine, Wesley Medical Center/UKSM-Wichita, 550 N. Hillside, Wichita 67214 — 316/688-2360

HIV Counseling and Testing Sites in Kansas

<u>Agency</u>	<u>Telephone</u>	<u>Agency</u>	<u>Telephone</u>
ARKANSAS CITY		LARNED	
Cowley County H.D.	(316) 442-3260	Pawnee County H.D.	(316) 285-6963
ATCHISON		LAWRENCE	
Atchison County H.D.	(913) 367-5152	Douglas County H.D.	(913) 843-0721
BURLINGTON		LEAVENWORTH	
Coffey County H.D.	(316) 364-8631	Leavenworth County H.D.	(913) 684-0730
CLAY CENTER		LIBERAL	
Clay County H.D.	(913) 632-3193	Seward County H.D.	(316) 624-3804
COFFEYVILLE		LYNDON	
Montgomery County H.D.	(316) 251-4210	Osage County H.D.	(913) 828-3117
COLBY		MANHATTAN	
Colby Community College	(913) 462-3984 ext. 296	Riley County H.D.	(913) 776-4779
Thomas County H.D.	(913) 462-7679	McPHERSON	
COLUMBUS		McPherson County H.D.	(316) 241-1753
Cherokee County H.D.	(316) 429-3087	MEADE	
CONCORDIA		Meade County H.D.	(316) 873-2842
Cloud Cty. Publ. Health	(913) 243-8140	MISSION	
DIGHTON		Johnson County H.D.	(913) 791-5660
Lane County H.D.	(316) 397-2333	NEODESHA	
DODGE CITY		Bert Chronister, M.D.	(316) 325-2622
Dodge City Family		Wilson County Hosp.	(316) 325-2611
Planning Clinic	(316) 225-1933	NEWTON	
EL DORADO		Harvey County H.D.	(316) 283-6900
Butler/Greenwood H.D.	(316) 321-3400	OLATHE	
EMPORIA		Johnson County H.D.	(913) 782-9400
Lyon County H.D.	(316) 342-4864	OSKALOOSA	
FORT SCOTT		Jefferson County H.D.	(913) 863-2447
SEK Multi-County H.D.	(316) 223-4464	OTTAWA	
FREDONIA		Franklin County H.D.	(913) 242-1873
Wilson County H.D.	(316) 378-4455	PARSONS	
GARDEN CITY		Labette County H.D.	(316) 421-4350
M*A*S*H	(316) 275-4077	PHILLIPSBURG	
Finney County H.D.	(316) 272-3600	Phillips County H.D.	(913) 543-2179
GOODLAND		PITTSBURG	
Sherman County H.D.	(913) 899-5627	Crawford County F.P.	(316) 231-3200
GREAT BEND		PRATT	
Barton County H.D.	(316) 793-7879	Pratt County H.D.	(316) 672-7436
HAYS		RUSSELL	
Ellis County H.D.	(913) 628-9440	Russell County H.D.	(913) 483-6433
Ft. Hays St. Univ.	(913) 628-4293	SALINA	
HIAWATHA		Saline County H.D.	(913) 827-9376
Brown County H.D.	(913) 742-7192	STOCKTON	
HOISINGTON		Rooks County H.D.	(913) 425-7352
Clara Barton Hosp.	(316) 653-2114	TOPEKA	
HUTCHINSON		Shawnee County H.D.	(913) 233-5141
Reno County H.D.	(316) 665-2900	ULYSSES	
IOLA		Grant County H.D.	(316) 356-1545
Allen County Hospital	(316) 365-3131	WICHITA	
JUNCTION CITY		Sedgwick County H.D.	(316) 268-8441
Geary County H.D.	(913) 762-5788	Wichita State Univ.	(316) 689-3620
KANSAS CITY		WINFIELD	
Kansas City-Wyandotte	(913) 321-4803 ext. 423	Cowley County H.D.	(316) 221-1430

Medical Specialty Codes

The medical specialties used in this directory are self-designated. Thus, they do not necessarily indicate certification by the board of the specialty indicated, nor are they indication of accreditation by the Accreditation Council for Graduate Medical Education.

The codes utilized are derived from the AMA Masterfile Codes for Self-Designation of Practice Specialties, as prepared by the Division of Survey and Data Resources, American Medical Association, March 1990.

A	Allergy	NM	Nuclear Medicine
ADL	Adolescent Medicine	NOTO	Neuro-otology
ADM	Administrative Medicine	NR	Nuclear Radiology
ADT	Addictionology	NS	Neurological Surgery
AM	Aviation Medicine	OBG	Obstetrics and Gynecology
AN	Anesthesiology	OM	Occupational Medicine
BLB	Pathology — Bloodbanking	ON	Oncology
CD	Cardiovascular Disease	OPH	Ophthalmology
CDS	Cardiovascular Surgery	ORS	Orthopedic Surgery
CDTS	Cardiovascular & Thoracic Surgery	OTO	Otorhinolaryngology
CHP	Child Psychiatry	P	Psychiatry
D	Dermatology	PA	Clinical Pharmacology
DR	Radiology, Diagnostic	PATH	Pathology
EENT	Eye, Ear, Nose and Throat	PD	Pediatrics
EM	Emergency Medicine	PDA	Pediatric Allergy
END	Endocrinology	PDC	Pediatric Cardiology
ENT	Ear, Nose Throat	PDE	Pediatric Endocrinology
ES	Endoscopy Surgery	PDN	Pediatric Neurology
FP	Family Practice	PNP	Pediatric Nephrology
GE	Gastroenterology	PDO	Pediatric Ophthalmology
GP	General Practice	PDS	Pediatric Surgery
GPM	General Preventive Medicine	PGER	Psychogerontology
GPVS	General & Peripheral Vascular Surgery	PH	Public Health
GS	General Surgery	PM	Physical Medicine & Rehabilitation
GYN	Gynecology	PS	Plastic Surgery
HEM	Hematology	PUD	Pulmonary Disease
ID	Infectious Diseases	R	Radiology
IE	Insurance Examination	RHU	Rheumatology
IM	Internal Medicine	RO	Radiology/Oncology
MFM	Maternal Fetal Medicine	SON	Surgical Oncology
N	Neurology	TR	Therapeutic Radiation
NEM	Neonatal-Perinatal Medicine	TS	Thoracic Surgery
NEP	Nephrology	U	Urology
		00	Retired

Medical School Codes

UNITED STATES

- | | |
|---|--|
| 0102 University of Alabama School of Medicine, Birmingham | 2802 Washington University School of Medicine, St. Louis |
| 0301 University of Arizona College of Medicine, Tucson | 2803 University of Missouri School of Medicine, Columbia |
| 0401 University of Arkansas School of Medicine, Little Rock | 2820 University Medical College of Kansas City |
| 0502 University of California School of Medicine, San Francisco | 2822 Ensworth Medical College, St. Joseph |
| 0506 University of Southern California School of Medicine, Los Angeles | 2834 St. Louis University School of Medicine, St. Louis |
| 0511 Stanford University School of Medicine, Palo Alto | 2843 Kansas City College of Medicine and Surgery |
| 0512 Loma Linda University School of Medicine, Loma Linda — Los Angeles | 2846 University of Missouri School of Medicine, Kansas City |
| 0514 University of California School of Medicine, Los Angeles | 2878 Kansas City College of Osteopathy & Surgery |
| 0515 University of California College of Medicine, Irvine | 2879 Kirksville College of Osteopathic Medicine, Kirksville |
| 0702 University of Colorado School of Medicine, Denver | 3005 University of Nebraska College of Medicine, Omaha |
| 0801 Yale University School of Medicine, New Haven | 3006 Creighton University School of Medicine, Omaha |
| 0802 University of Connecticut, Farmington | 3007 Nebraska College of Medicine, Lincoln |
| 1001 George Washington University School of Medicine, Washington, D.C. | 3305 College of Medicine & Dentistry of New Jersey — New Jersey Medical School, Newark |
| 1002 Georgetown University School of Medicine, Washington, D.C. | 3401 University of New Mexico School of Medicine, Albuquerque |
| 1003 Howard University College of Medicine, Washington, D.C. | 3501 Columbia University College of Physicians and Surgeons, New York |
| 1102 University of Miami School of Medicine, Miami | 3503 Albany Medical College of Union University, Albany |
| 1103 University of Florida College of Medicine, Gainesville | 3506 State University of New York at Buffalo, School of Medicine, Buffalo |
| 1201 Medical College of Georgia, Augusta | 3508 State University of New York College of Medicine, Brooklyn |
| 1205 Emory University School of Medicine, Atlanta | 3509 New York Medical College, New York |
| 1601 Rush Medical College, Chicago | 3510 Bellevue Hospital Medical College, New York |
| 1602 University of Chicago Pritzker School of Medicine, Chicago | 3515 State University of New York College of Medicine, Syracuse |
| 1604 The Hahnemann Medical College and Hospital, Chicago | 3519 New York University School of Medicine, New York |
| 1606 Northwestern University Medical School, Chicago | 3520 Cornell University Medical College, New York |
| 1611 University of Illinois College of Medicine, Chicago | 3545 University of Rochester School of Medicine and Dentistry, Rochester |
| 1642 Chicago Medical School University of Health Sciences, Chicago | 3546 Albert Einstein College of Medicine of Yeshiva University, New York |
| 1643 Loyola University Stritch School of Medicine, Maywood | 3547 Mount Sinai School of Medicine of City University of New York, New York |
| 1645 Southern Illinois School of Medicine, Springfield | 3601 University of North Carolina School of Medicine, Chapel Hill |
| 1676 Chicago College of Osteopathic Medicine, Chicago | 3605 Bowman Gray School of Medicine, Winston-Salem |
| 1720 Indiana University School of Medicine, Indianapolis | 3607 Duke University School of Medicine, Durham |
| 1803 University of Iowa College of Medicine, Iowa City | 3737 University of North Dakota, Grand Forks |
| 1875 College of Osteopathic Medicine and Surgery, Des Moines | 3802 Eclectic Medical College, Cincinnati |
| 1902 University of Kansas School of Medicine, Kansas City | 3806 Case Western Reserve University School of Medicine, Cleveland |
| 2002 University of Louisville School of Medicine, Louisville | 3819 Toledo Medical College, Toledo |
| 2012 University of Kentucky College of Medicine, Lexington | 3840 Ohio State University College of Medicine, Columbus |
| 2101 Tulane University School of Medicine, New Orleans | 3841 University of Cincinnati College of Medicine, Cincinnati |
| 2105 Louisiana State University School of Medicine, New Orleans | 3843 Medical College of Ohio at Toledo, Toledo |
| 2106 Louisiana State University Medical Center, Shreveport School of Medicine, Shreveport | 3901 University of Oklahoma School of Medicine, Oklahoma City |
| 2201 Bowdoin Medical School, Brunswick-Portland | 3979 Oklahoma College of Osteopathic Medicine and Surgery, Tulsa |
| 2301 University of Maryland School of Medicine, Baltimore | 4002 University of Oregon Medical School, Portland |
| 2307 Johns Hopkins University School of Medicine, Baltimore | 4101 University of Pennsylvania School of Medicine, Philadelphia |
| 2401 Harvard Medical School, Boston | 4102 Jefferson Medical College of Thomas Jefferson University, Philadelphia |
| 2405 Boston University School of Medicine, Boston | 4107 Medical College of Pennsylvania, Philadelphia |
| 2407 Tufts University School of Medicine, Boston | 4109 Hahnemann Medical College and Hospital, Philadelphia |
| 2416 University of Massachusetts School of Medicine, Worcester | 4112 University of Pittsburgh School of Medicine, Pittsburgh |
| 2501 University of Michigan Medical School, Ann Arbor | 4113 Temple University School of Medicine, Philadelphia |
| 2507 Wayne State University School of Medicine, Detroit | 4114 Pennsylvania State University, Milton S. Hershey Medical Center, Hershey |
| 2512 Michigan State University College of Human Medicine, East Lansing | 4177 Philadelphia College of Osteopathic Medicine, Philadelphia |
| 2604 University of Minnesota Medical School, Minneapolis | 4201 University of Puerto Rico School of Medicine, San Juan |
| 2701 University of Mississippi School of Medicine, Jackson | 4301 Brown University Division of Biological and Medical Sciences, Providence |

- 4501 Medical University of South Carolina College of Medicine, Charleston
- 4705 Vanderbilt University School of Medicine, Nashville
- 4706 University of Tennessee College of Medicine, Memphis
- 4707 Meharry Medical College School of Medicine, Nashville
- 4720 East Tennessee State University School of Medicine, Johnson City
- 4802 University of Texas Medical Branch, Galveston
- 4804 Baylor College of Medicine, Houston
- 4812 University of Texas Southwestern Medical School, Dallas
- 4813 University of Texas Medical School, San Antonio
- 4814 University of Texas Medical School, Houston
- 4815 Texas Tech University School of Medicine, Lubbock
- 4816 Texas A&M University College of Medicine, College Station

- 4878 Texas College of Osteopathic Medicine, Ft. Worth
- 4901 University of Utah College of Medicine, Salt Lake City
- 5002 University of Vermont College of Medicine, Burlington
- 5101 University of Virginia School of Medicine, Charlottesville
- 5104 Medical College of Virginia Health Sciences Division of Virginia Commonwealth University, Richmond
- 5107 Eastern Virginia Medical School, Norfolk
- 5404 University of Washington School of Medicine, Seattle
- 5501 West Virginia University School of Medicine, Morgantown
- 5605 University of Wisconsin Medical School, Madison
- 5606 Medical College of Wisconsin, Milwaukee

FOREIGN MEDICAL SCHOOL CODES

CANADA

- 060 Alberta
- 06001 University of Alberta Faculty of Medicine, Edmonton
- 06002 University of Calgary Faculty of Medicine, Calgary
- 061 British Columbia
- 06101 University of British Columbia Faculty of Medicine, Vancouver
- 062 Manitoba
- 06201 University of Manitoba Faculty of Medicine, Winnipeg
- 065 Ontario
- 06501 University of Toronto Faculty of Medicine, Toronto
- 06505 Queen's University Faculty of Medicine, Kingston
- 06506 University of Western Ontario Faculty of Medicine, London
- 067 Quebec
- 06701 McGill University Faculty of Medicine, Montreal

OTHER FOREIGN

- 118 Afghanistan
- 11801 Faculty of Medicine, Kabul University, Kabul
- 132 Argentina
- 13201 Facultad de Ciencias Medicas de la Universidad de Buenos Aires, Buenos Aires
- 13202 Facultad de Ciencias Medicas de la Universidad Nacional de Cordoba, Cordoba
- 13204 Facultad de Ciencias Medicas, Farmacia y Ramos Menores de la Universidad Nacional del Litoral, Rosario, Santa Fe
- 13206 Facultad de Ciencias Medicas de la Universidad Nacional de Cuyo, Mendoza, Mendoza
- 143 Australia
- 14303 Faculty of Medicine University of Sydney, Sydney, New South Wales
- 154 Austria
- 15407 Medizinische Fakultät der Universität Wien, Wien (407-26 from March 13, 1938 to June, 1945)
- 160 Bangladesh
- 16002 Dacca Medical College, Ramna Dhaka, Bangladesh
- 165 Belgium
- 16501 Faculte de Medecine et de Pharmacie Universite libre de Bruxelles, Bruxelles
- 16504 Universitaire Katholique de Louvain, Faculte de Medecine, Louvain
- 176 Bolivia
- 17602 Facultad de Ciencias Medicas de la Universidad Mayor Real y Pontificia de San Francisco Xavier de Chuquisaca, Sucre
- 17603 Facultad de Medicina de la Universidad Mayor de San Simon, Cochabamba
- 187 Brazil
- 18708 Universidade Federal de Parana, Faculdade de Medicina, Curitiba, Parana

- 209 Burma
- 20901 Institute of Medicine I, Rangoon
- 215 Cambodia
- 21501 Ecole Royal de Medicine du Cambode, Phnompenh
- 231 Chile
- 23101 Facultad de Medicina de la Universidad de Chile, Santiago
- 242 China
- 242 China (also see 243 Effective January 1, 1977)
- 24209 St. John's University (Pennsylvania Medical School, Shanghai, Kiangsu) (Extinct)
- 24216 National Shanghai Medical College, Shanghai, Kiangsu
- 24217 West China Union University College of Medicine and Dentistry, Chengtu, Szechuan
- 24222 Aurora University Faculty of Medicine, Shanghai, Kiangsu (Extinct)
- 24239 Shansi University Medical College, Taiyuan, Shansi
- 243 China
- 24338 National Honan University Medical College, Kaifeng, Honan (24238 Prior to 1-17-1)
- 24351 National Defense Medical Center, School of Medicine, Shanghai, Kiangsu (24251 Prior to 1-17-1)
- 244 Taiwan
- 244 Taiwan (Formosa) effective 1-17-1
- 24402 College of Medicine National Taiwan University, Taipei (38502 Prior to 1-17-1)
- 24404 Taipei Medical College, Taipei (38504 Prior to 1-17-1)
- 24405 China Medical College, Taichung (38505 before 1971)
- 264 Colombia
- 26401 Facultad de Medicina de la Universidad Nacional de Colombia Ciudad Universitaria, Bogota, Cundinamarca
- 26402 Facultad de Medicina de la Universidad de Cartagena, Cartagena, Bolivar
- 26404 Facultad de Medicina de la Pontificia Universidad Javeriana, Bogota, Cundinamarca
- 26406 Facultad de Medicina de la Universidad de Caldas, Manizales, Caldas
- 26407 Facultad de Medicina de la Universidad del Cauca, Popayan, Cauca
- 275 Cuba
- 27501 Facultad de Medicina de la Universidad de la Habana, La Habana
- 27502 Escuela de Medicina, Universidad de Oriente, Santiago
- 286 Czechoslovakia
- 28601 Deutsche Univerzita Medizinische Fakultä, Praha (15405 before 1919)
- 28602 Charles Univerzita Fakultä of PedGen Medicine, Praha
- 308 Dominican Republic
- 30801 Facultad de Medicina de la Universidad de Santo Domingo, Ciudad, Trujillo
- 30803 Universidad Central Del Este
- 30805 Instituto Tecnológico de Santo Domingo, Santo Domingo
- 30807 Universidad Cetec, Escuela De Medicina, Santo Domingo
- 319 Ecuador
- 31901 Facultad de Ciencias Medicas de la Universidad Central, Quito

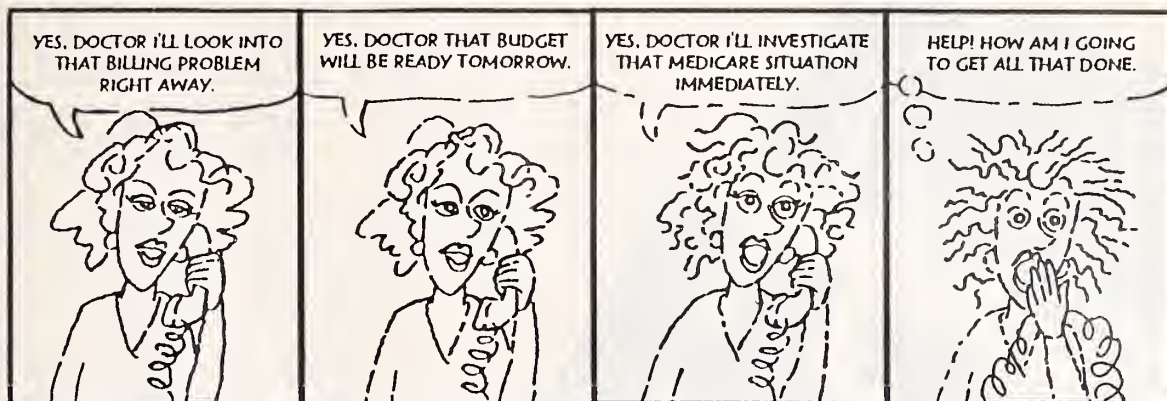
- 330 Egypt (United Arab Republic)**
 33002 Kasr-el-Aini Faculty of Medicine, Cairo University, Cairo (Formerly Fouad First University Faculty of Medicine)
 33003 Faculty of Medicine Alexandria University, Alexandria
 33004 Abbasis Faculty of Medicine, University of Ein Shams, Cairo
- 341 El Salvador**
 34104 Facultad de Medicina Universidad Nacional del Salvador, San Salvador
- 352 England**
 35204 University of Newcastle-Upon-Tyne Medical School (Before August 1963 Kings College University in Durham)
 35205 School of Medicine University of Leeds, Leeds
 35207 University of London Faculty of Medicine, London
 35211 Registrable Qualifications granted by English Conjoint Board (Royal College of Surgeons of England/Royal College of Physicians of London)
- 385 Formosa (Taiwan)**
 385 (Also see 244 Taiwan [Effective 1-17-1])
 38501 Kaohsiung (takau) Medical College, Kaohsiung
 38502 College of Medicine National Taiwan University, Taipei
 38503 National Defense Medical Center, Taipei
 38505 China Medical College, Taichung
- 396 France**
 39606 Faculte de Medecine de l'Universite de Paris, Paris, Seine
 39607 Faculte mixte de Medecine et de Pharmacie de l'Universite de Toulouse, Toulouse, Haute-Garonne
- 407 Germany**
 407 Also see 408409—East and West Germany (Effective 1-1-71)
 40707 Medizinische Fakultät der Georg-August-Universität, Göttingen, Niedersachsen
 40710 Medizinische Fakultät der Universität Heidelberg, Heidelberg, Baden-Württemberg
 40715 Medizinische Fakultät der Philipps-Universität, Marburg/Lahn, Hessen
 40716 Medizinische Fakultät der Ludwig Maximilians-Universität, München, Bayern
 40721 Medizinische Fakultät der Universität Hamburg, Hamburg
 40723 Medizinische Fakultät der Johann-Wolfgang-Goethe-Universität, Frankfurt-Am-Main, Hessen
 40733 Medizinische Fakultät der Freien Universität Berlin, Berlin
- 409 Germany West**
 40902 Medizinische Fakultät Rheinischen Friedrich Wilhelms Universität, Bonn (40702 before 1971)
 40905 Medizinische Fakultät Albert-Ludwigs-Universität Freiburg IM Breisgau
 40921 Medizinische Fakultät Universität Hamburg, Hamburg (40721 before 1971)
 40933 Medizinische Fakultät Freien Universität, Berlin, Berlin (40733 Prior to 1-1-71)
- 418 Greece**
 41801 Faculty of Medicine National University of Athens, Athens
 41802 Faculty of Medicine University of Thessaloniki, Thessaloniki
- 429 Guatemala**
 42901 Facultad de Ciencias Medicas, Universidad de San Carlos, Guatemala
- 451 Honduras**
 45101 Facultad de Medicina y Cirugia de la Universidad Nacional Autonoma de Honduras, Tegucigalpa
- 473 Hungary**
 47301 Orvosi Fakultás Tudományegyetem, Budapest
- 495 India (Goa)**
 49501 University of Bombay, Affiliated Medical Colleges are:
 a. Grant Medical College Bombay University, Bombay, Maharashtra
 b. Seth Gorhandas Sunderdas Medical College Bombay University, Bombay, Maharashtra
 49503 Guru Nanak Medical College, Guru Nanak University, Amritsar, Punjab
 49504 Madras Medical College Madras University, Madras, Madras
 49508 Christian Medical College Punjab University, Ludhiana, Punjab
 49509 St. John's Medical College, Bangalore, Mysore (before June 1966: Government Medical College, Mysore University, Mysore)
 49511 Andhra Medical College Andhra University, Visakhapatnam, Andhra
- 49515 Prince of Wales Medical College, Patiala University, Bankipore Patiala, Bihar
 49516 Stanley Medical College Madras University, Madras, Madras
 49517 Topiwala National Medical College, Bombay University, Bombay, Maharashtra
 49518 Assam Medical College Gauhati University, Dibrugarh, Assam
 49520 M.G.M. Medical College, Indore Madhya Pradesh
 49521 Osmania Medical College Osmania University, Hyderabad, Andhra
 49523 Medical College Baroda University, Baroda, Gujarat
 49527 Christian Medical College, Vellore, Madras
 49528 Byramjee Jeejeebhoy Medical College, Poona, Maharashtra
 49529 Government Medical College Punjab University, Patiala, Punjab
 49530 Sawai Man Singh Medical College Rajasthan University, Jaipur, Rajasthan
 49531 Medical College Kerala University, Trivandrum, Kerala
 49533 Medical College, Bangalore University, Mysore
 49534 Gajra Rao Medical College Vikram University, Gwalior, Madhya Pradesh
 49535 Karnatak Medical College Karnatak University, Hubli, Mysore
 49536 All-India Institute of Medical Sciences, New Delhi, Delhi
 49537 Kasturba Medical College Karnatak University, Manipal, Mysore
 49541 G.S.V. Memorial Medical College Lucknow University, Kanpur, Uttar Pradesh
 49547 Medical College Jabalpur University, Jabalpur, Madhya Pradesh
 49548 M.P. Shah Medical College Gujarat University, Jamnagar, Gujarat
 49549 Ghandhi Medical College Vikram University, Bhopal, Madhya Pradesh
 49550 Guntur Medical College Andhra University, Guntur, Andhra
 49552 St. John's Medical College, Bangalore University, Bangalore, Mysore
 49554 Rajendra Medical College, Ranchi, Bihar
 49555 Sardar Patel Medical College, Bikaner
 49557 Kakatiya Medical College, Warangal, Andhra Pradesh
 49568 College Medicine Sciences Banaras Hindu University, Varanasi, Uttar Pradesh
 49573 Armed Forces Medical College, Poona
 49574 Ravindra Nath Tagore Medical College, Udaipur
 49576 Municipal Medical College, Gujarat University, Ahmedabad, Gujarat
 49596 Lokmanya Tilak Mun Medical College, Bombay University, Bombay, Maharashtra
 49597 Dr. Vaishampayan Memorial Medical College, Shivaji University, Shalapur, Maharashtra
 49610 M.L.B. Medical College, Juansi
- 496 India**
 49611 Sri Krishna Medical College, Muzaffarpur, Bihar
- 506 Indonesia**
 50602 Faculty of Medicine Airlangga Airlangga University, Surabaya
- 517 Iran**
 51701 Faculty of Medicine University of Teheran, Teheran
 51703 Faculty of Medicine, Tabriz
- 528 Iraq**
 52801 Faculty of Medicine Baghdad University, Baghdad
- 539 Ireland**
 53901 Faculty of Medicine Queen's University of Belfast, Belfast
 53902 National University of Ireland, Constituent Colleges are:
 a. Faculty of Medicine University College, Dublin
 b. Faculty of Medicine University College, Cork
 c. Faculty of Medicine, Galway
- 53903 School of Physic Trinity College University of Dublin, Dublin
- 550 Israel**
 55001 The Hebrew University-Hadassah Medical School, Jerusalem
- 561 Italy**
 56101 Facoltà di Medicina e Chirurgia dell'Università di Bologna, Bologna
 56115 Facoltà di Medicina e Chirurgia dell'Università di Perugia, Perugia
 56119 Facoltà di Medicina e Chirurgia dell'Università di Siena, Siena
- 572 Japan**
 57211 Tokyo Medical College (Nippon Ikadaigaku) Hongo, Tokyo (Extinct)
 57241 Faculty of Medicine Shinshu University, Matsumoto, Nagano
 57249 Tokyo Medical College, Tokyo
- 583 Korea (South)**
 58301 Severence Medical College Yonsei University, Seoul

- 58302 College of Medicine Seoul National University, Seoul
 58303 Korea University Medical College, Seoul
 58304 College of Medicine Kyong-Puk National University, Taegu
 58306 College of Medicine Chun Nam National University, Kwangju
 58309 College of Medicine Pusan National University, Pusan
 58310 College of Medicine Catholic University, Seoul
- 05 Lebanon**
 60501 Medical School American University of Beirut, Beirut
- 627 Malta**
 62701 Faculty of Medicine and Surgery Royal University of Malta, Valetta
- 649 Mexico**
 64901 Facultad de Medicina de la Universidad Nacional Autonoma de Mexico, Mexico
 64902 Facultad de Medicina de la Universidad de Nuevo Leon, Monterrey, Nuevo Leon
 64906 Facultad de Medicina de la Universidad Nacional del Sureste, Merida, Yucatan
 64914 Facultad de Medicina de la Universidad Autonoma de Guadalajara, Guadalajara, Jalisco
 64933 Universidad Autonoma de Ciudad Juarez, Ciudad Juarez, Chihuahua
 64936 Centro de Estudios Universidad Xochicalo A.C., Cuernavaca, Morelos
- 660 Netherlands**
 66061 Faculteit der Geneeskunde Universiteit Van Amsterdam, Amsterdam
- 671 New Zealand**
 67101 Medical School University of Otago, Dunedin
- 704 Pakistan**
 70401 King Edward Medical College, Lahore, West Pakistan
 70402 Dow Medical College, Karachi, Federal Capital Area
 70403 Dacca Medical College, Dacca, East Pakistan
 70404 Nishtar Medical College, Multan, West Pakistan
 70409 Khyber Medical College, Peshawar, North-West Frontier Province
 70410 Chittagong Medical College, Chittagong, East Pakistan (16001 after 7-1-72)
- 726 Paraguay**
 72601 Facultad de Medicina de la Universidad Nacional de Asuncion, Asuncion
- 737 Peru**
 73701 Facultad de Medicina de San Fernando de la Universidad Nacional Mayor de San Marcos, Lima
 73705 Facultad de Medicina de la Universidad Nacional de San Agustin, Arequipa
 73706 Facultad de Medicina "Cayetano Heredia" de la Universidad Peruana de Ciencias Medicas y Biologicas, Lima
- 748 Philippines**
 74801 Faculty of Medicine and Surgery University of Santo Tomas, Manila
 74802 College of Medicine University of the Phillipines, Manila
 74807 College of Medicine Manila Central University, Manila
 74808 Institute of Medicine Far Eastern University, Manila
 74809 College of Medicine Southwestern University, Cebu City
- 74810 College of Medicine University of the East, Quezon City
 74811 College of Medicine Cebu Institute of Technology, Cebu City
- 759 Poland**
 75903 Warsaw Medical Academy
 75911 Akademia Medyczna, Bialystock
- 803 Scotland**
 80301 Faculty of Medicine University of Aberdeen, Aberdeen
 80302 University of St. Andrews School of Medicine, Dundee
 80303 Faculty of Medicine University of Edinburgh, Edinburgh
 80305 Faculty of Medicine University of Glasgow, Glasgow
- 836 South Africa**
 83601 Medical School University of the Witwatersrand, Johannesburg
- 847 Spain**
 84701 Facultad de Medicina de la Universidad de Barcelona, Barcelona
 84703 Facultad de Medicina de la Universidad de Grenada, Grenada
 84704 Facultad de Medicina de la Universidad de Madrid, Madrid
 84706 Facultad de Medicina de la Universidad de Zaragoza, Zaragoza
 84708 Facultad de Medicina de la Universidad de Valencia, Valencia
 84710 Facultad de Medicina de la Universidad de Salamanca, Salamanca
 84711 Facultad de Medicina de la Universidad Catolica Navarra, Pamplona
- 869 Switzerland**
 86901 Medizinische Fakultät der Universität Basel, Basel
 86902 Medizinische Fakultät der Universität Bern, Bern
 86905 Faculté de Médecine de l'Université de Lausanne, Lausanne
- 875 Syria**
 87501 Faculty of Medicine Damascus University, Damascus
- Taiwan (See Formosa)**
- 891 Thailand**
 89101 Faculty of Medicine at Chulalongkorn Hospital University of Medical Sciences, Bangkok
 89102 Faculty of Medicine at Sariraj Hospital University of Medical Sciences, Thonburi
 89104 Faculty of Medicine at Ramathibodi Hospital, Mahidol University, Bangkok
- 902 Turkey**
 90201 Tıp Fakültesi İstanbul Üniversitesi, İstanbul
 90205 Hacettepe University Faculty of Medicine, Ankara
- 913 Union of Soviet Socialist Republics**
 91302 Voronezh Medical Institute, Voronezh
- 917 United Kingdom-England-Wales**
 91707 University of London Faculty of Medicine, London (35207 before 1971)
- 941 Viet-Nam South**
 94101 Faculté mixte de Médecine et de Pharmacie Université de Saïgon, Saïgon
- 945 Udaipur**
 94574 Ravindra Nath Tagore Medical College, Udaipur
- 957 Yugoslavia**
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ADAMS MD,DWIGHT, OSAGE CITY
ADLI MD,CEMAL M, LAS VEGAS,NV
AGUSTIN MD,CONRADO M, WICHITA
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AHLSTRDM MD,NANCY G, WICHITA
AHMAO MD,ABOU Q, EL ODRADO
AHMEO MD,IFTEKHAR, KANSAS CITY,MO
AHNEMANN MD,JANET L, KANSAS CITY
AHUJA,KIRAN S, SHAWNEE MISSION
AILLDN MD,ALEJANDRO J, HALSTEAD
AKERS MD,GUY I, FORT SCOTT
ALBERS MD,ROBERT C, HAYS
ALBRIGHT MD,JEROLD O, HUTCHINSON
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ALOOROTY MD,NEIL, WICHITA
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ALFONSO MD,MANUEL, WICHITA
ALGIE MD,WILLIAM H, KANSAS CITY
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ALLEGRE MD,ANN, KANSAS CITY
ALLEN JR MD,WILLIAM R, KANSAS CITY
ALLEN MO,FRANCES A, NEWTON
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ALLEN MD,JAMES V, SHAWNEE MISSION
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ALLEN MD,RAY E, LIBERAL
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ALLEN SR MD,WILLIAM R, KANSAS CITY
ALLEN,JAY L, SHAWNEE MISSION
ALLIN MD,DENNIS M, SHAWNEE MISSION
ALLMAN RYAN,LORI, SHAWNEE MISSION
ALMONTE MD,PRISCILLA C, WICHITA
ALMONTE MD,ROOOLFO O, WICHITA
ALQUIST MD,VERYL D, BAXTER SPRINGS
ALSOPI MD,WILLIAM R, SALINA
ALTENBERND MD,ELVIN C, SHAWNEE MISSION
ALTER MD,BRUCE R, ST FRANCIS
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ALVAREZ MD,NDRBERTO, ARKANSAS CITY
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AMAWI MD,MOHAMMAO S, DOOGIE CITY
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AMEND MD,DOUGLAS J, EMPORIA
AMINI MD,JAFAR, KANSAS CITY,MO
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AMMAR MD,ALEX O, WICHITA
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ANDERSON MD,JODY, SALINA
ANDERSON MD,LARRY R, WELLINGTON
ANDERSON MD,LYLE B, BLODMINGTON,IN
ANDERSON MD,WILLIAM A, SHAWNEE MISSION
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ANDERSON,OEBOORAH A, KANSAS CITY
ANDERSON,SUSAN R, SHAWNEE MISSION
ANTRIM MD,PHILIP JENIFER, ANTHONY
APPENFELLER MD,WILLIAM D, OSAWATOMIE
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 BUBECK MD,RALPH W, WICHITA
 BUCK JR MD,BEN H, WICHITA
 BUCK JR MD,HENRY W, LAWRENCE
 BUCK JR MD,WILLIAM D, BLUE RAPIDS
 BUCKMAN MD,MARTIN SPALDING, SHAWNEE MISSION
 BUDETTI MD,JOSEPH A, N MIAMI BEACH,FL
 BULA MD,RALPH E, HAYS
 BULLER MD,DAVID L, MCPHERSON
 BURCH,CINCY M, SHAWNEE MISSION

BURES JR MD,GEORGE J, SHAWNEE MISSION
 BURGER MD,PAUL B, SHAWNEE MISSION
 BURGER MD,WILLIAM E, BASEHUR
 BURGESS MD,FRANK G, EMPDRIA
 BURGESS MD,ARTHUR P, OSWEGO
 BURGETT,PAUL M, JAMESTOWN,ND
 BURKE MD,JAMES J, FORT SCOTT
 BURKE MD,JOSEPH V, ATCHISON
 BURKE MD,MICHAEL J, WICHITA
 BURKET JR MD,GEORGE E, KINGMAN
 BURKMAN MD,REUBEN J, CHANUTE
 BURNETT D O,LARRY E, SALINA
 BURNETT MD,A DEAN, HALSTEAD
 BURNIEY II MD,WILLIAM W, WICHITA
 BURNIEY MD,WILLIAM W, WICHITA
 BURNS,LISA A, COLUMBUS,DH
 BURPEE MD,JAMES F, WICHITA
 BURT MD,RONALD J, DNAGA
 BUSER MD,WILLIAM D, SHAWNEE MISSION
 BUSHELL,KRISTEN, KANSAS CITY
 BUSTOS MD,JDNAS G, HERINGTON
 BUTCHER MD,THOMAS P, EMPDRIA
 BUTH MD,DENNIS K, WICHITA
 BUTIN MD,J WALKER, WICHITA
 BUTLER MD,DDRIS C, WICHITA
 BUTRICK MD,CHARLES W, SHAWNEE MISSION
 BUTT MD,MUHAMMED, CLAY CENTER
 BYERS MD,JONELL, SALINA
 BYRNE MD,JAMES PERRY, WICHITA
 BYRNES MD,JOHN J, OLATHE

C

CABRERA MD,ALBERT, MCPHERSON
 CABRERA,ANTHONY, KANSAS CITY
 CACHIA MD,RICHARD M, TOPEKA
 CAEOO MD,CARMELITA D, LIBERAL
 CALBECK MD,JOHN, GARDEN CITY
 CALDERON MD,JAIME, KANSAS CITY
 CALIENOO JR MD,DANIEL J, WICHITA
 CALKINS MD,JOHN W, KANSAS CITY
 CALKINS MD,LARRY L, SHAWNEE MISSION
 CALLAGHAN,EDWARD J, LEXINGTON,VA
 CAMERON MD,WILLIAM J, KANSAS CITY
 CAMERON,JEFF W, SHAWNEE MISSION
 CAMPBELL JR MD, WILLIAM R, OVERLAND PARK
 CAMPBELL MD,EDWARD G, EMPORIA
 CAMPBELL MD,GARLANO L, ARKANSAS CITY
 CAMPBELL MD,LINO H, HUTCHINSON
 CAMPBELL MD,WILLIAM H, COFFEYVILLE
 CAMPBELL,ELIZABETH A, SHAWNEE MISSION
 CAMPION MD,MARY K, WICHITA
 CANNADAY MD,JOHN J, SALINA
 CANNATA MD,GENE, GREENSBURG
 CANNON MD,MICHAEL W, WICHITA
 CAO,THAI H, KANSAS CITY
 CAPPER MD,STANLEY L, WICHITA
 CAREY MD,LARRY J, PARSONS
 CARLIE MD,WILLIAM E, WICHITA
 CARLSON MD,EARL V, HAYS
 CARLSON MD,TERRY S, WICHITA
 CARLSSON MD, E R, LINOSBORG
 CARNAHAN MD,ROBERT L, LAWRENCE
 CARNEY MD,LISA A, SHAWNEE MISSION
 CAROTHERS,KARREL L, MILWAUKEE,WI
 CARPENTER MD,PAUL R, KANSAS CITY
 CARPER MD,IVAN H, NEWTON
 CARPER MD,OWEN E, NEWTON
 CARPINO,STEPHANIE J, SHAWNEE MISSION
 CARR MD,SUSAN L, WICHITA
 CARREAU MD,ERNEST P, CEOAREOGE,CO
 CARRO MD,ALBERTO F, WICHITA
 CARRO MD,ANTONIO L, MULVANE
 CARVER,DEBORAH L, TOPEKA CITY
 CARVER,RONALD C, SHAWNEE MISSION
 CASEY MD,JAMES L, HUTCHINSON
 CASHMAN JR MD,MAURICE R, TOPEKA
 CASIDY,SHANNON L, SHAWNEE MISSION
 CASTEEL MD,CHARLES K, SHAWNEE MISSION
 CASTRISOS,JAMES C, WICHITA
 CATE MD,BAIN C, WICHITA
 CATHCART-RAKE MD,WILLIAM F, SALINA
 CATHEY MD,ROBERT H, MANHATTAN
 CATD LONER MD,TERI A, PITTSBURGH,PA
 CATTANEO MD,ERNEST A, SHAWNEE MISSION
 CATTANEO,JOHN E, TULSA,OK
 CAUBLE MD,WILBUR G, WICHITA
 CAUGHLIN MD,GERALD MICHAEL, WICHITA
 CAVANAUGH MD,CLAIR J, GREAT BEND
 CAVANAUGH MD,TERRENCE J, GREAT BEND
 CAVANAUGH MD,TIMOTHY B, BALTIMORE,MO
 CAWLEY MD,LEO P, SCOTSDALE,AZ
 CECIL III MD,JOHN, HAYS
 CEOERLIND MD,CRANSTON JAY, SHAWNEE MISSION
 CESARETTI MD,LUKE S, HUTCHINSON
 CHAFFEE MD,DEAN C, ABILENE
 CHAFFEE MD,TERRY L, KANSAS CITY
 CHALIAN MD,ALEXANDER R, KANSAS CITY
 CHALLA MD,SHEKHAR K, TOPEKA
 CHAMBERLIN JR MD,CECIL R, NEWPORT,OR
 CHANEY MD,ERNIE J, WICHITA
 CHANG MD,C H JOSEPH, KANSAS CITY
 CHANG MD,FREOERIC C, WICHITA

CHANG MD,PHILEMON D, INDEPENDENCE
 CHANG,CRAIG G, KANSAS CITY
 CHANG,MORRIS, WICHITA
 CHAPMAN MD,THOMAS C, WICHITA
 CHARD MD,FREDERICK H, WICHITA
 CHAVES MD,ENRIQUE, KANSAS CITY
 CHAVEZ MD,CARLOS A, HDLTON
 CHAVEZ MD,STEVE, WICHITA
 CHEDIAK MD,ELIAS, LAWRENCE
 CHEN MD,CHU-CHI, TOPEKA
 CHEN MD,TAK-MING, TOPEKA
 CHEN,EDWARD C, KANSAS CITY
 CHENG MD,MEI Y, WICHITA
 CHERNOFF MD,MARY A, KANSAS CITY
 CHERRY JR MD,ARTHUR C, TOPEKA
 CHERVEN MD,PHILIP L, WICHITA
 CHEUNG MD,LAURENCE Y, KANSAS CITY
 CHHATRE MD,MAOHUKAR, KANSAS CITY
 CHI MD,IL-SUNG, WICHITA
 CHILLAL MD,PANDURANG P, COFFEYVILLE
 CHIN MD,TOM D, KANSAS CITY
 CHO MD,CHENG T, KANSAS CITY
 CHD MD,SECHIN, WICHITA
 CHD,STEVE Y, WICHITA
 CHDI MD,PHILIP S, PARSONS
 CHDNKO MD,ARNOLD M, KANSAS CITY
 CHOPRA MD,AMAN, WICHITA
 CHDTIMDNKOL MD,ANUPONG, ODDGE CITY
 CHDW MD,STANLEY Y, FORT SCOTT
 CHOWHARY MD,RAVI, SHAWNEE MISSION
 CHOY MD,JAMES K L, SUN CITY,AZ
 CHRISTENSEN MD,ERIC C, KANSAS CITY,MO
 CHRISTENSEN MD,SHANE R, KANSAS CITY,MO
 CHRISTIAN,MARY K, WICHITA
 CHRISTMAN JR MD,CARL, WICHITA
 CHRONISTER MD,BERT, NEOESHA
 CHUNG MD,JOHN J, SHARON SPRINGS
 CISKEY MD,WILLIAM J, EUREKA
 CLAASSEN MD,MILTON A, NEWTON
 CLAASSEN MD,SAMUEL D, MCPHERSON
 CLAIBORNE MD,RICHARD A, WICHITA
 CLARK MD,CDURNEY, WICHITA
 CLARK MD,CRAIG N, TOPEKA
 CLARK MD,DAVID H, SALINA
 CLARK MD,FRANCIE H, WICHITA
 CLARK MD,LAURENCE A, WAMEGO
 CLARK MD,RAY A, LAKE CHAS,LA
 CLARK MD,ROBERT G, WICHITA
 CLAWSON MD,D KAY, KANSAS CITY
 CLIFTON MD,H DAVID, WICHITA
 CLINE MD,BYRON W, WICHITA
 CLOUGH,JOHN A, KANSAS CITY
 COALE MD,LLOYD H, KANSAS CITY
 COATES,SCOTT O, CHANUTE
 COATS MD,BARBARA S, WICHITA
 COBB MD,JEANNINE M, WICHITA
 COBB MD,LESLIE H, MULVANE
 COCHRAN MD,PAUL W, TOPEKA
 COCHRAN,KIMBERLY A, OLATHE
 COFFEY MD,CHARLES R, WICHITA
 COHEN MD,JUSTIN THOMAS, WICHITA
 COHEN MD,LOUIS, TOPEKA
 CDHEN MD,ROBERT A, SHAWNEE MISSION
 COHLMIA MD,JERRY B, WICHITA
 COHLMIA,SAM N, WICHITA
 COKER MD,W LAURENCE, TOPEKA
 COLE MD,RICHARD F, CANEY
 CDLE MD,WARO M, WELLINGTON
 COLEMAN MD,GARY, ABILENE
 COLEMAN MD,ROBERT L, SHAWNEE MISSION
 COLEMAN MD,THOMAS J, WICHITA
 COLLIER MD,HAROLD W, WICHITA
 COLLIER MD,WILLIAM J, MCPHERSON
 COLLINS MD,DEAN T, TOPEKA
 COLLINS MD,EDWARD J, TOPEKA
 COLLINS MD,JEFFREY S, KINGSVILLE,TX
 CDLYER MD,JEFFREY W, WASHINGTON,DC
 CONANT MD,FERRILL R, SMITH CENTER
 CONANT MD,MERRILL, DOOG CITY
 CONARD MD,CLAIR C, DODGE CITY
 CONCANNON MD,CRAIG A, BELOIT
 CONCEPCION JR MD,EUGENIO S, WICHITA
 CONE,PATRICIA A, KANSAS CITY
 CONNELL,CHRISTINA Y, WICHITA
 CONNER MD,BRIAN, SALINA
 CONOVER MD,MARGARET A, TOPEKA
 CONRARDY MD,PETER A, WICHITA
 CONROW MD,JEFFREY K, TOPEKA
 CONROY MD,ROBERT W, TOPEKA
 COOK D O, RANDY A, HAYS
 COOK MD,DONALD RAY, WICHITA
 COOK MD,G EDWARD, WICHITA
 COOK MD,JAMES D, KANSAS CITY
 COOK MD,KARDLYN M, LARNED
 COOK MD,THEODORE R, LARNED
 CODLEY MD,DAVID A, SHAWNEE MISSION
 COOLEY MD,ENNIS M, TOPEKA
 COOMER MD,TYLER E, PITTSBURG
 COON MD,STEPHEN D, TOPEKA
 COOPER MD,ARTHUR E, NORTON
 COOPER MD,CATHY N, EL DORADO
 COOPER MD,JACK R, SHAWNEE MISSION
 CODPER MD,JAMES L, SALINA
 COOPER MD,LED F, DREXEL,MO
 COOPER MD,M KENT, WICHITA
 COPENING MD,TELL B, OLATHE
 COPPLE JR MD,HAL E, TOPEKA
 CORBIN MD,MURRAY D, KANSAS CITY

*Probationary members.

CORDELL MD,LARRY D, SHAWNEE MISSION
CROER MD,ROBERT L, ST JOSEPH,MO
CORNELL MD,EARL G, PARSONS
CORNELL,CAPT KELLEY, TRAVIS AFB,CA
COSSETTE MD,JERROLD E, SALINA
COSSMAN MD,F PRICE, WICHITA
COSTA,JDHN A, SHAWNEE MISSION
COSTELLO MD,J W, HUTCHINSON
COTTON MD,RDERT T, TOPEKA
COULTER D O, THAYNE A, CLYDE
COULTER MD,HENRY F, SHAWNEE MISSION
COULTER MD,THOMAS B, SHAWNEE MISSION
COVERT MD,THOMAS J, SALINA
COVILLO D O,D,FREDERICK V, KANSAS CITY
COX O O,DEON M, CHICAGO,IL
COX III MD,IRA L, KANSAS CITY
COX JR MD,IRA, SHAWNEE MISSION
COX MD,ANNE L, CONCORDIA
COX MD,GLENDON G, SHAWNEE MISSION
COX MD,ROBERT H, HAYS
COX,REAGAN M, KANSAS CITY
COX,STEVEN W, KANSAS CITY
COYLE,DEBORA S, WICHITA
CRADDOCK,TERRY M, KANSAS CITY
CRAIG MD,CHARLES C, NEWTON
CRAIG MD,THOMAS A, JUNCTION CITY
CRAM JR MD,DLE R, LARNED
CRAM MD,ERNEST R, ST FRANCIS
CRANE MD,CHARLES H, MANHATTAN
CRANE MD,OAVIO D, WICHITA
CRANE WHITE MD,REBECCA, ARKANSAS CITY
CRARY MO,JOHN E, TOPEKA
CREDITOR MD,MORTON C, KANSAS CITY
CRISP-LINDGREN MD,NADMA, WICHITA
CROCKETT MD,CHARLES A, SHAWNEE MISSION
CRONIN MD,DONALD J, WICHITA
CROSKELL,SARAH E, SALT LAKE CITY,UT
CROSS LODKE,KAREN K, ALTON,MO
CROUCH MD,STEVEN W, TOPEKA
CROUCH MD,WILLIAM H, TOPEKA
CRDW MD,ERNEST W, WICHITA
CRDWLEY MD,EDWARD X, WICHITA
CULLAN MD,GEORGE E, HUTCHINSON
CULLAN MD,SAMUEL K, KANSAS CITY,MO
CULP MD,LOUIS M, KANSAS CITY
CULTRON MD,FRANK T, SALINA
CULVER O O,SONYA KATHERINE, ERIE
CULVER MD,WARREN T, LAWRENCE
CUMMINGS MD,RICHARD J, WICHITA
CUPPAGE MD,FRANCIS E, KANSAS CITY
CURTIS MD,JEFFERY L, TOPEKA
CURTIS,STEPHEN L, KANSAS CITY
CZAPANSKY-BEILMAN MD,DESIREE, WICHITA

D

D'SOUZA MD,BISMARCK C, SALINA
DAHL MD,DAVID C, KANSAS CITY
DAIZ MD,ANTONIO S, PARSONS
DAKHIL MD,SHAKER R, WICHITA
DALUM MD,PETER JOSEPH, CLAY CENTER
DAMIANI DD,STEPHEN M, WICHITA
DAMMON JR MD,JAMES W, TOPEKA
DANBY MD,JOHN H, WICHITA
DANIELS MD,HERBERT A, KANSAS CITY
DANIELS MD,RDERT M, VALLEY CENTER
DANIELS PETRAKIS,PATRICIA M, KANSAS CITY
DARGER MD,KATHERINE, WICHITA
DARR MD,RICHARD B, SHAWNEE MISSION
DARRAH MD,JOY N, WICHITA
DATTTEL,FREDERICK, SHAWNEE MISSION
DATTILO MD,RAYMOND, TOPEKA
DAUGHETY MD,TED W, TOPEKA
DAVIA MD,JAMES E, SHAWNEE MISSION
DAVIDSON,RANDY G, WICHITA
DAVIES,JOHNATHAN W R, KANSAS CITY
DAVIS O O,CODY W, HUGOTON
DAVIS MD,CHESTER R, TOPEKA
DAVIS MD,CHRISTOPHER G, KANSAS CITY
DAVIS MD,DAVID R, EMPORIA
DAVIS MD,KEVIN B, NEWTON
DAVIS MD,PAUL H, WICHITA
DAVIS MD,RICHARD E, KANSAS CITY,MO
DAVIS MD,RONALD B, WICHITA
DAVIS MD,W D, HUTCHINSON
DAVISON MD,JOE D, WICHITA
DAY MD,HOWARD, WICHITA
DE BAKKER MD,JAN B, WICHITA
DE BOISE MD,DOUGLAS, WICHITA
DE HART MD,ARTHUR DONIVA, WICHITA
DE LA PEDRAJA,JOSE L, KANSAS CITY
DE WITT MD,BARBARA L, KANSAS CITY
DEAN MD,DAVID P, WICHITA
DEBIASSE MD,DEBRA J, SALINA
DECKER MD,DONALD O, HALSTEAD
DEFREECE,DANIEL J, WICHITA
DEGNER MD,JAMES C, WICHITA
DEGNER MD,REX A, GREAT BEND
DEITZ MD,MICHAEL R, SHAWNEE MISSION

DEJONG MD,DAVID C, WICHITA
DELCDRE MD,ROMANO, KANSAS CITY
DELGADO MD,SERGID, TOPEKA
DELGADO MD,SERGID VICTOR, TOPEKA
DELMORE MD,JAMES E, WICHITA
DELPHIA MD,ROBERT E, DLAHE
DEMOS MD,ELEANDR P, WICHITA
DEMOTT MO,WAYNE R, KANSAS CITY
DENISON MD,TERRY R, SHAWNEE MISSION
DENNING MD,DALE P, LAWRENCE
DENNIS MD,DAVID T, SALINA
DENNIS MD,MICHAEL W, SHAWNEE MISSION
DEPENBUSCH MD,FRANCIS L, HUTCHINSON
DEPEW MD,CLIFFORD S, WICHITA
DERRINGTON MD,KENNETH L, SHAWNEE MISSION
DETURK MD,DWAYNE L, SALINA
DEVINE,ROBERT P, KANSAS CITY,MO
DEVINS MD,GEORGE S, KANSAS CITY,MO
DEYSS MD,MARK R, WICHITA
DIALLO MD,GASTON I, LEAVENWORTH
DIANO,MARCEL L, KANSAS CITY
DICK JR MD,HENRY J, EMPORIA
DICK MD,WILLIS G, IDLA
DICKY,SUSAN D, KANSAS CITY
DICKINSON MD,CHARLES R, COFFEYVILLE
DICKINSON,JAMES M, KANSAS CITY,MO
DIEHL MD,ANTONI M, SHAWNEE MISSION
DIENER MD,CLAYTON H, HESSTON
DILLARD MD,SANDY R, WICHITA
DILLON MD,STEVEN C, PRATT
DILLON MD,WILLIAM L, PARSONS
DINSDALE MD,ROBERT C, LAWRENCE
DIXON MD,RAYMOND W, COFFEYVILLE
DDAK MD,BASCOM P, NESS CITY
DOAN MD,TRINAH, WICHITA
DOBBS MD,MICHAEL E, HUTCHINSON
DOBRTZ MD,ROBERT A, BELOIT
DOBRTZ,DAVID E, ST PETERSBURG,FL
DOCKHORN MD,ROBERT J, SHAWNEE MISSION
DOEBLIN MD,P LAURENCE, WICHITA
DOHERTY MD,WILLIAM R, PALM DESERT,CA
DOLAN JR MD,PHILIP JARVIS, WICHITA
DOMME JR MD,SYLVESTER A, WICHITA
DONATELLE MD,EDWARD P, WICHITA
DONEPUDI MD,RAO S, TOPEKA
DONLEY MD,JAMES L, SHAWNEE MISSION
DONNELL MD,JAMES M, WICHITA
DONNELLY MD,WILLIAM P, SHAWNEE MISSION
DONOBOS MD,DANIEL C, WICHITA
DORN MD,CURTIS C, WICHITA
DORSCHE MD,JOHN N, WICHITA
DOSS MD,J RICHARD, HAYS
DOUBEK MD,OEBA L, KANSAS CITY
DOUBEK MD,HERBERT D, BELLEVILLE
DOUGHERTY JR MD,THOMAS M, LARNED
DOUGHERTY MD,THOMAS M, GARNETT
DOUTHIT MD,DOUGLAS DAVID, WICHITA
DOWNARD MD,JAMES M, COLUMBIA,MO
DOWNING MD,GREGORY C, WICHITA
DRAEMEL MD,H RICHARD, SALINA
DRAHDA MD,LAWRENCE J, SHAWNEE MISSION
DRAKE MD,CYNTHIA K, SHAWNEE MISSION
DRAKE MD,DOUGLAS J, BELOIT
DRAKE MD,RALPH L, WICHITA
DRASIN MD,DENA K, SHAWNEE MISSION
DRAZEK MD,GEORGE, WICHITA
DRAZEK MD,JANE K, WICHITA
DREHER MD,HENRY S, SALINA
DREILING MD,ROGER J, SHAWNEE MISSION
DREVETS MD,CURTIS C, WICHITA
DUCKETT II MD,THOMAS G, SHAWNEE MISSION
DUCKETT MD,THOMAS G, HIAWATHA
DUGGEDN MD,MAUREEN, SHAWNEE MISSION
DUGAN MD,DAVID L, WICHITA
DUGGINS,MAURICE L, WICHITA
DUICK MD,GREGORY, WICHITA
DUJOVNE MD,CARLOS A, KANSAS CITY
DULIN MD,JOSE I, KANSAS CITY
DUNAGIN MD,JACK A, TOPEKA
DUNCAN MD,KIRK A, SHAWNEE MISSION
DUNIVEN MD,PHILIP L, TOPEKA
DUNLAP MD,PATRICK S, FORT SCOTT
DUNLAP MD,RICHARD L, LAWRENCE
DUNN MD,DANIEL R, SCOTT CITY
DUNN MD,MARVIN I, KANSAS CITY
DUNSHIE MD,CARLYLE M, FORT SCOTT
DUNSHIE MD,CHERYL A, FORT SCOTT
DURAND MD,ANTONIO C, WICHITA
DURHAM,JANE, SHAWNEE MISSION
DURKEE MD,BRUCE W, SHAWNEE MISSION
DURKEE MD,WILLIAM R, MANHATTAN
DURST JR MD,ROBERT D, TOPEKA
DUTTA MD,SAKUNTALA S, WICHITA
DUYSAK MD,SAMI, LEAVENWORTH
DYCK MD,ERIC LEE, SHAWNEE MISSION
DYCK MD,GEORGE, NEWTON
DYE MD,JAMES D, VIRGINIA BEACH,VA
DYE,DIANNA P, KANSAS CITY
DYSART MD,JACK C, STERLING

E

EASTON MD,GARY DEAN, HALSTEAD
EATON MD,EDWARD L, TOPEKA

EATON MD,GLEN E, SALINA
EATON MD,LESLIE F, SALINA
ECK MD,MARIE M, WICHITA
ECKART MD,DE MERLE E, HUTCHINSON
ECKERT MD,WILLIAM G, WICHITA
ECKERT,CYNTHIA S, KANSAS CITY
EDDY MD,VICTOR M, HAYS
EDEL,THOMAS A, KANSAS CITY
EDMONDS MD,MARTA J, SHAWNEE MISSION
EDEL,THOMAS, KANSAS CITY
EDWARDS MD,DAVID J, EMPORIA
EDWARDS MD,MANIS C, WICHITA
EDWARDS MD,SHELLEY J, SHAWNEE MISSION
EGBERT MD,ANNE MARSH, WICHITA
EGELHOF MD,RICHARD H, WICHITA
EICHORN MD,FRANK D, GARDEN CITY
EINSPAHR MD,DAVID E, WICHITA
EL-GHAZZAWY,ADEL G, KANSAS CITY
EL-SABA MD,MEKKI M, FORT SCOTT
ELANDVAN MD,SUDHA, WICHITA
ELCDCK MD,DAVID G, SHAWNEE MISSION
ELDER MD,D MIKEL, TOPEKA
ELLIS MD, S CHRISTOPHER, SHAWNEE MISSION
ELLIS MD,BOBBY J, INDEPENDENCE
ELLIS MD,HOWARD D, SHAWNEE MISSION
ELLIS,STEVEN F, CHICAGO,IL
ELLISON MD,PAUL D, SALINA
EMAMI MD,ABBAS, KANSAS CITY
EMMOTT MD,DAVID F, SHAWNEE MISSION
EMPSON MD,CHARLES L, INDEPENDENCE
ENDERS MD,WRAY, SHAWNEE MISSION
ENGELKEN MD,SUSAN F, ONAGA
ENGEN MO,PHIL L, KANSAS CITY
ENNS MD,EUGENE K, NEWTON
ENNS MD,JAMES H, LAKE HAVASU CITY,AZ
ENDCH III,DUARO W, SHAWNEE MISSION
ENOCH MD,ROLLAND, WICHITA
ENS MD,GERHARD GEDRGE, HILLSBORO
ENS MD,PETER D, HILLSBORO
ENSRDTH MD,KENNETH A, TOPEKA
EPLER MD,JOHN R, ATCHISON
EROWEN MD,BARBARA A, KANSAS CITY
ERENBERG MD,ALLEN, KANSAS CITY
ERICKSON MD,CLARENCE W, PITTSBURG
ERICKSON MD,KENT E, CLAY CENTER
ERNST MD,TARI MAE, WICHITA
ESCH MD,JOHN G, ISLAND PARK,MO
ESRIG O O, HAROLD L, SHAWNEE MISSION
ESTEP MD,THOMAS H, WICHITA
ESTES MD,NORMAN C, KANSAS CITY
ESTIVO D O,MICHAEL P, WICHITA
ESTRADA MD,EDMUNDO C, LIBERAL
ETZENHUSER III MD,RUSSELL D, SHAWNEE MISSION
EVANS JR MD,WILLIAM E, SHAWNEE MISSION
EVANS MD,CAROL ANN, SHAWNEE MISSION
EVANS MD,FARRIS D, WICHITA
EVANS MD,JOHN F, WICHITA
EVANS MD,RICHARD G, KANSAS CITY
EVANS MD,ROGER WILLIAMS, WICHITA
EVANS MD,WILLIAM R, GREAT BEND
EVANS,GENE H, WICHITA
EWING MD,DAVID L, KANSAS CITY
EYSTER MD,ROBERT L, WICHITA

F

FAILING MD,TRENT L, DLAHE
FAIRCHILD MD,RICHARD S, TOPEKA
FAKHURY,MARK, INDIANAPOLIS,IN
FALTER MD,RICHARD T, HUTCHINSON
FALTER,RICHARD T, KANSAS CITY
FARHA MD,AYHAM J, WICHITA
FARHA MD,GEORGE J, WICHITA
FARHA MD,S JIM, WICHITA
FARHAT MD,ASSEM Z, WICHITA
FARLEY MD,JAMES A, WICHITA
FARMER III D.O., F J, STAFFORD
FAST MD,GARY A, WICHITA
FAST MD,ROBERT E, ATCHISON
FAST MD,W SPENCER, ATCHISON
FAULK,L CHRISTINE, KANSAS CITY
FEAGAN MD,JERRY, TOPEKA
FEAGINS ALEXANDER MD,SHIRLEY J, WICHITA
FEAREY MD,ALAN J, WICHITA
FEEDR MD,BARBARA, HALSTEAD
FEHAN MD,JOHN M, DLAHE
FEIFAREK MD,MICHAEL J, TOPEKA
FEIGHNY MD,ROBERT E, SALINA
FELDMAYER MD,SEELEY T, MEADE
FELT MD,SAMUEL E, WICHITA
FENT II MD,LEE S, HAYS
FENT MD,LEE S, NEWTON
FENTON MD,ROBERT M, GAROEN CITY
FERGUSON DD,ELAINE L, SALINA
FERGUSON,DIANE M, KANSAS CITY
FERNANDEZ MD,HECTOR O, WICHITA
FERNANOEZ MD,LUIS A, TOPEKA
FERRARI MD,VICTOR S, KANSAS CITY
FERREE MD,RICHARD ALLAN, MCHPERSON
FERRIS MD,BRUCE G, WICHITA
FEUILLE JR MD,EDMOND G, WICHITA
FIELD MD,RICHARD A, TOPEKA
FIELD-KRESIE MD,DEBBIE A, TOPEKA
FIELD,CHARLES E, KANSAS CITY

*Probationary members.

FIEN D D, STEPHEN, WICHITA
 FIELDS MO,GALEN W, MCPHERSON
 FIEBER MO,CARL W, GREAT BEND
 FIFE,EDGAR A, KANSAS CITY
 FINK MO,ABRAHAM A, PLANTATION,FL
 FINLEY MO,BRENT E, KANSAS CITY
 FISCHER MO,REX R, MANHATTAN
 FISCHER,KENNY A, KANSAS CITY
 FISHER MO,JAMES B, COLORADO SPRINGS,CO
 FISHER MO,RAY F, WICHITA
 FISHER,KAY, KANSAS CITY
 FITZGERALD DO,DAVID J, WICHITA
 FITZGERALD MO,DAVID A, TOPEKA
 FITZGERALD MO,EDWARD J, WICHITA
 FITZIG MO,SANFORD, WICHITA
 FITZPATRICK HARRIS MO,PAMELA, KANSAS CITY
 FITZSIMMONS,CURTIS J, KANSAS CITY
 FLANDERS MO,H ALDEN, MC ALLEN,TX
 FLATT MO,DAVID, WICHITA
 FLEMING MO,FORNEY W, WICHITA
 FLEMING,DOONNA J, KANSAS CITY
 FLESKE MO,LEONARD T, GREAT BEND
 FLOERSCH MO,HUBERT M, LAWRENCE
 FLOWERS JR MO,CLELL B, WICHITA
 FORD MO,CHARLES R, WICHITA
 FOROYCE MO,NORMAN, EMPORIA
 FORET MO,JOHN O, KANSAS CITY
 FORREO MO,WALTER, WICHITA
 FORSTER MO,JAMESON, KANSAS CITY
 FORTIN MO,DAVID, LAWRENCE
 FORTUNE MO,CEORIC B, OLAHE
 FOSS MO,DANIEL C, HUTCHINSON
 FOSTER MO,O BERNARD, TOPEKA
 FOSTER MO,FRANCES J, KANSAS CITY
 FOWLER MO,ENNIS L, OLAHE
 FOWLER MO,ROBERT J, WICHITA
 FOWLER MO,WAYNE L, CONCORDIA
 FOX MO,DEANNA K, KANSAS CITY
 FRANCIS MO,ANTHONY E, SALINA
 FRANCIS MO,NORTON L, WICHITA
 FRANCISCO MO,CLARENCE L, SHAWNEE MISSION
 FRANCISCO MO,DAN A, WICHITA
 FRANCISCO MO,LINDA L, WICHITA
 FRANCISCO MO,W OAVIO, KANSAS CITY
 FRANK MO,GEORGE M, BEAVERTON,OR
 FRANK MO,MARY S, TOPEKA
 FRANK,KENNETH J, SHAWNEE MISSION
 FRANKEL MO,SCOTT J, SHAWNEE MISSION
 FRANKLIN JR MO,BENJAMIN A, TOPEKA
 FRANSSEN MO,PAUL H, HALSTEAD
 FREDRICKSON MO,DUANE E, LINDSBORG
 FREDRICKSON,DAVID P, TOPEKA
 FREDRICKSON,ERIC R, KANSAS CITY
 FREEBORN JR MO,WARREN S, AMES
 FREEMAN MO,F GILES, PRATT
 FREEMAN MO,FRED A, MANHATTAN
 FREEMAN MO,RAYMOND S, SALINA
 FRENCH MO,JAMES E, WICHITA
 FRENCH MO,JEROME E, WICHITA
 FRENKEL MO,JACOB K, SANTA FE,NM
 FRESE MO,DANIEL R, COUNCIL GROVE
 FREUND MO,WILLIAM L, TOPEKA
 FRIESEN MO,DALE, LAWRENCE
 FRIESEN MO,DOUGLAS A, HUTCHINSON
 FRIESEN MO,DOUGLAS L, HALSTEAD
 FRIESEN MO,ORLANDO J, NEWTON
 FRIESEN MO,RICK W, PRATT
 FRIESEN MO,STANLEY R, SHAWNEE MISSION
 FRISKEL,ERIC O, KANSAS CITY
 FRITZ,DAVID, NEWTON
 FRITZE MO,MARK H, WICHITA
 FRITZMEIER MO,WILLIAM H, WICHITA
 FROMER MO,JOEL, WICHITA
 FROMM MO,ARTHUR H, WICHITA
 FUECHTING MO,LYNNE A, NEWTON
 FRY MO,LUTHER L, GARDEN CITY
 FUGATE MO,CARL L, BELOIT
 FULBRIGHT MO,THOMAS W, LAWRENCE
 FULLEN MO,JERYL G, SALINA
 FULTON MO,JOHN K, WICHITA
 FUNK MO,EDWARD O, EUORA

G

GABBARD MO,GLEN O, TOPEKA
 GABRIELLI JR MO,WILLIAM F, SHAWNEE MISSION
 GAEDDERT,WADE A, COLUMBIA,MO
 GAFFNEY MO,GARY R, KANSAS CITY
 GAGE MO,BETSE M, SHAWNEE MISSION
 GAGNON MO,SUZANNE, WICHITA
 GALICHTIA MO,JOSEPH P, WICHITA
 GALLEHUGH MO,KEITH W, SHAWNEE MISSION
 GALLVAN MO,ALONSO, WICHITA
 GAMBLE MO,DOONNA O, OOOGE CITY
 GANDHI MO,SHANTIKUMAR K, TOPEKA
 GANN MO,E LAMONTE, EMPORIA
 GANS MO,FREDERICK A, SALINA
 GANZARAIN MO,RAMON C, TOPEKA
 GARCIA MO,GOULO C, EMPORIA
 GARCIA MO,GUILLEMO O, OOOGE CITY

GARCIA-FERRER MO,FRANCISCO, SHAWNEE MISSION
 GARD MO,RAYMOND F, REDDING,CA
 GARDNER MO,J DOUGLAS, TOPEKA
 GARONER MO,JAMES D, MANHATTAN
 GARONER MO,JAREO J, WICHITA
 GARLOW MO,WILLIAM B, SALINA
 GARNER,STEVEN A, KANSAS CITY
 GARNER,WILLIAM J, SHAWNEE MISSION
 GATSCHE MO,TIMOTHY P, HAYS
 GAUGHAN EXEC OIR,CAROLYN N, WICHITA
 GAUGHAN MO,MICHAEL J, SHAWNEE MISSION
 GAUGHAN MO,REBECCA N, OLAHE
 GAY MO,JOHN D, TOPEKA
 GEENENS D D, DOUGLAS L, BOSTON,MA
 GEHRT MO,EARL B, CHANUTE
 GEIS MO,OLICK A, TOPEKA
 GEIST MO,MICHAEL J, TOPEKA
 GEITZ MO,JAMES M, EMPORIA
 GEMPERLI,AMY WISE, SHAWNEE MISSION
 GENCH MO,RAYMOND L, CARMEL,CA
 GENDEL MO,JOSEPH E, TOPEKA
 GENILD MO,CELESTE A, WICHITA
 GENTRY MO,JAMES H, DENVER,CO
 GENTRY MO,KALE C, SHAWNEE MISSION
 GEORGE MO,EARL F, WICHITA
 GERJARUSAK MO,PRAPAS, SHAWNEE MISSION
 GERWICK MO,CHARLES L, SHAWNEE MISSION
 GETTLER MO,DEAN T, FORT SCOTT
 GIBBONS MO,ROBERT T, SHAWNEE MISSION
 GIESSEL MO,MICHAEL O, TOPEKA
 GILBERT II MO,JOHN H, GARDEN CITY
 GILHOUSEN MO,FREDERIC M, KANSAS CITY
 GILLAN JR MO,DALE EDWIN, HUTCHINSON
 GILLEN MO,BILLY A, SHAWNEE MISSION
 GILLENWATER MO,DAVID T, WICHITA
 GILLES MO,HELEN M, LAWRENCE
 GILLILANO MO,CRAIG L, KANSAS CITY
 GILLOGLY,MARILYN B, SHAWNEE MISSION
 GILMARTIN MO,RICHARD C, WICHITA
 GIMPLE MO,KENNETH, TOPEKA
 GINAVAN MO,DUANE A, EMPORIA
 GIROUX MO,GUY M, TOPEKA
 GLEASON MO,JIMMIE A, TOPEKA
 GLEASON,DOUGLASS S, KANSAS CITY
 GLENN MO,JAMES N, EMPORIA
 GLENN MO,LYLE G, PROTECTION
 GLOVER II MO,RICHARD M, SHAWNEE MISSION
 GLOVER MO,RICHARD M, NEWTON
 GNAU MO,FREDRIC B, HALSTEAD
 GODFREY MO,WILLIAM A, KANSAS CITY,MO
 GOODWIN MO,PHILLIP A, LAWRENCE
 GOERING MO,DOONALD O, COLORADO
 GOERING MO,RANDALL V, WICHITA
 GOERTZ MO,LEO R, SHAWNEE MISSION
 GOINS MO,BONNIE K, SHAWNEE MISSION
 GOLOBERG MO,HERBERT R, WICHITA
 GOLOBERG,MARCEL A, KANSAS CITY
 GOLOSTEIN MO,ESTELLE T, WICHITA
 GOLOSTEIN MO,GERALD L, SHAWNEE MISSION
 GOLDSTEIN,JOYCE, SHAWNEE MISSION
 GOLLIER II MO,ROBERT A, OTTAWA
 GOLLUB MO,STEVEN B, KANSAS CITY
 GOMETZ MO,MOOESTO S, PITTSBURG
 GOMEZ MO,FRANCISCO, SHAWNEE MISSION
 GONZALEZ MO,HIRAM, WICHITA
 GONZALEZ,IRIS P, COYAHAGA FALLS,OH
 GOOD O O,FREDERICK C, WICHITA
 GOOD MO,JAMES T, FORT SCOTT
 GOOD MO,WENDELL L, SHAWNEE MISSION
 GOODPASTURE MO,HEWITT C, WICHITA
 GOODWIN MO,DOONALD W, KANSAS CITY
 GOODWIN MO,JOHN A, SHAWNEE MISSION
 GOODWIN MO,MARY K, GOODARD
 GOODWIN MO,JAMES R, WICHITA
 GOTO MO,HIROSHI, KANSAS CITY
 GOYLE MO,KRISHAN K, WICHITA
 GOYLE MO,VIMAL, WICHITA
 GRABAU MO,GUY M, OKLAHOMA CITY,OK
 GRACE,CAROL, SHAWNEE MISSION
 GRAESSLE O O,DOONNA M, SHAWNEE MISSION
 GRAHAM JR MO,ARNOLD R, KANSAS CITY
 GRAHAM MO,BRUCE O, KANSAS CITY,MO
 GRAHAM MO,JAMES R, KANSAS CITY,MO
 GRAHAM MO,KENNETH L, LEAVENWORTH
 GRAHAM,JOHN O, WICHITA
 GRAINGER MO,DAVID A, WICHITA
 GRANT MO,MICHAEL O, SALINA
 GRANT MO,MICHAEL E, WICHITA
 GRANTHAM MO,HERBERT G, FORT SCOTT
 GRANTHAM MO,JAREO J, KANSAS CITY
 GRANTHAM,J AARON, SHAWNEE MISSION
 GRASHOFF MO,JOYCE A, SHAWNEE MISSION
 GRATNY,LINDA L, LEAVENWORTH
 GRAUEL MO,CHARLES W, WICHITA
 GRAVES MO,JACK W, WICHITA
 GRAVES MO,KATHRYN, HUTCHINSON
 GRAY MO, C K, SHAWNEE MISSION
 GRAY MO,C LUCIEN, WICHITA
 GRAY MO,DAVID E, TOPEKA
 GRAY MO,H TOM, WICHITA
 GRAY MO,PATRICK W, PONCA CITY,OK
 GRAY,APRIL K, KANSAS CITY,MO
 GRAYIB MO,ANTOINE S, TOPEKA
 GREEN,BART P, WICHITA
 GREEN,JUSTIN L, KANSAS CITY
 GREEN,KEITH W, WICHITA
 GREENBERG MO,GEORGE E, DODGE CITY
 GREENBERG MO,MARK, TOPEKA
 GREENBERGER MO,N J, KANSAS CITY

GREENE MO,HORACE T, TOPEKA
 GREENE MO,LAWRENCE S, KANSAS CITY
 GREENE MO,RUSSELL E, TOPEKA
 GREENFIELD,MICHAEL A, SHAWNEE MISSION
 GREENWOOD MO,JAMES F, GARDEN CITY
 GREENWOOD MO,MELANIE A, WICHITA
 GREER MO,JAMES A, WICHITA
 GREER MO,RICHARD H, TOPEKA
 GRENE MO,ROBERT BRUCE, WICHITA
 GRIEBEL MO,DOONNA J, WICHITA
 GRIFFITH MO,FRANK H, SALINA
 GRIFFITT MO,WESLEY E, KANSAS CITY
 GRILLOT MO,FLOYD B, PALM HARBOR,FL
 GRILLDT MO,MICHAEL B, WICHITA
 GRIMALDI MO,GARY A, PITTSBURG
 GRIMES MO,I ROSS, LIBERAL
 GRIMES MO,JAMES T, LYONS
 GRIN MO, TRUOI R, SHAWNEE MISSION
 GRINDEL DO,STEPHEN J, WICHITA
 GRINIS MO,GEORAS M, HUTCHINSON
 GRISOLIA MO,ANDRES, LEAVENWORTH
 GRISSOM MO,RHONDA G, SHAWNEE MISSION
 GRISWOLD MO,DALE G, NEWTON
 GROSS MO,BRIAN M, WICHITA
 GROSSER,DAVID M, SHAWNEE MISSION
 GROSSMAN MO,HARVEY M, SHAWNEE MISSION
 GROTH,STEPHAN J, SHAWNEE MISSION
 GROWNEY MO,DANIEL J, ATCHISON
 GRUENDEL MO,RICHARD A, KANSAS CITY
 GRUENDEL MO,VIRGINIA T, KANSAS CITY
 GRUNDMEIER MO,ANNETTE M, SHAWNEE MISSION
 GRUSHNYS MO,ARNOLD, WICHITA
 GSELL MO,GEORGE F, WICHITA
 GUILLAUME,CAROLE A, KANSAS CITY
 GUNN MO,MARVIN R, SALINA
 GUPTA MO,GANESH G, WICHITA
 GUPTA,ARCHANA, WICHITA
 GUTHRIE MO,RICHARD A, WICHITA
 GUTDITZ MO,ALLEN LOUIS, TOPEKA
 GUTTIKONDA MO,PRASAD B, WARREN,OH

H

HABASHY MO,SHAWKY N F, WICHITA
 HACKER MO,DAVID C, SHAWNEE MISSION
 HACKER MO,ELAINE MARY, TOPEKA
 HADLEY MO,DELMONT C, OTTAWA
 HAFNER MO,WILLIAM N, EL DORADO
 HAGAN MO,C THOMAS, WICHITA
 HAGAN MO,FRANCIS J, WICHITA
 HAGAN MO,ROBERT C, WICHITA
 HAGAN MO,STEPHEN F, WICHITA
 HAGGAN MO,MARGARET E, LAWRENCE
 HAIGLER MO,JAMES P, HAYS
 HALE MO,RALPH, HUTCHINSON
 HALE MO,WILLIAM R, NEWTON
 HALL III MO,THOMAS B, KANSAS CITY
 HALL MO,J ROGER, WICHITA
 HALL MO,MARK R, SHAWNEE MISSION
 HALL MO,ROY P, TOPEKA
 HALL MO,WESLEY H, GIRARD
 HALLER MO,CHRIS C, LEAVENWORTH
 HALLERAN III MO,WILLIAM J, SHAWNEE MISSION
 HALLEY MO,M MARTIN, TOPEKA
 HALLFORD MO,JASPER C, GARDEN CITY
 HALLING MO,L WILLIAM, HAYS
 HALVORSON BEESLEY,KARI J, OLAHE
 HALVORSON MO,HOWARD C, OLAHE
 HAMEL MO,GREGORY L, CHAPMAN
 HAMILTON JR MO,JAMES J, TOPEKA
 HAMILTON MO,JAMES J, WAKEENEY
 HAMILTON,DEBORAH K, WICHITA
 HAMM MO,GLENN, NEWTON
 HAMM MO,ORVAL L, NEWTON
 HAMMEKE MO,JOHN C, LEAVENWORTH
 HAMPEL MO,KEVIN G, WICHITA
 HAMILT MO,LAWRENCE W, SHAWNEE MISSION
 HAN MO,CHAN S, COFFEYVILLE
 HANCOCK MO,ALAN C, KANSAS CITY
 HANCOCK MO,DANIEL E, MANHATTAN
 HANDS MO,SEBEL V, AMARILLO,TX
 HANOSHY MO,STANLEY E, ERIE
 HANNA,DEBRA S, KANSAS CITY
 HANNAH,ANNE B, LIBERTY,MO
 HANSEN MO,ERIC E, TOPEKA
 HANSEN MO,FRANK W, GARDEN CITY
 HANSON MO,DAVID C, HUTCHINSON
 HARA MO,GLENN S, KANSAS CITY
 HARBIN MO,GARY LYNN, SALINA
 HARO MO,BENJAMIN F, KANSAS CITY,MO
 HARON,DAVID W, WICHITA
 HAROLD MO,CREIGHTON A, SHAWNEE MISSION
 HAROTEN MO,DAVID R, BROOKLYN PARK,MN
 HARMS MO,EDWIN M, NEWTON
 HARMS MO,WILMER A, HALSTEAD
 HARRINGTON MO,ELAINE M, WICHITA
 HARRIS JR MO,CLAIB B, GARNETT
 HARRIS MO,FRANK H, WICHITA
 HARRIS MO,HUBERT L, TOPEKA
 HARRIS MO,LANNY W, SHAWNEE MISSION
 HARRIS MO,MARGARET H, SHAWNEE MISSION
 HARRIS MO,NORMAN R, CLEARWATER,FL
 HARRIS MO,PATRICIA A, TOPEKA

*Probationary members.

HARRIS,BRYAN O, KANSAS CITY
HARRISON MD,HALL E, TOPEKA
HARRISON MD,PAUL BARRY, WICHITA
HARRISON,PAMELA D, WICHITA
HART MD,DILLIS L, WICHITA
HART MD,JOHN J, WICHITA
HART MD,KELLY Z, KANSAS CITY
HART MD,LAWRENCE E, ATCHISON
HARTL,KELLY LIZABETH, KANSAS CITY
HARTER MD,TERRY L, HOLTON
HARTIG JR,DONALD E, WICHITA
HARTLEY MD,FDUNT K, WICHITA
HARTLEY MD,JAMES M, WICHITA
HARTLEY MD,RDY W, NORTON
HARTMAN MD,GERALD V, SHAWNEE MISSION
HARTMAN MD,KECK R, WICHITA
HARTMAN MD,ROGER L, NORTON
HARTONG MD,TOBY JOSEPH, SHAWNEE MISSION
HARTONG MD,WILLIAM A, SHAWNEE MISSION
HARTWELL MD,KIMBERLY, WICHITA
HARTWELL MD,RICK L, WICHITA
HARTY MD,JEAN R, KANSAS CITY
HARVEY MD,R CLAY, TOPEKA
HARVEY MD,RDSEMARY B, WICHITA
HARWOOD MD,CLAUDE J, GLASCO
HARWOOD MD,MICHAEL R, KANSAS CITY
HASKINS MD,ROBERT J, WICHITA
HASLETT MD,MARK G, TOPEKA
HASSAN MD,RIZWAN U, WICHITA
HASSELLE III MD,JAMES E, LAWRENCE
HASSLER MD,RANDY D, SALINA
HASTINGS MD,GLEN E, WICHITA
HASWELL,JAMES, WINSTON SALEM,NC
HATCHER MD,ELIZABETH R, TOPEKA
HATESOHL MD,STANLEY M, CLAY CENTER
HATFIELD,ALLYSON A, WICHITA
HATHAWAY MD,PETER, KANSAS CITY,MO
HATTAMER,STEVEN, SHAWNEE MISSION
HATTON MD,DONALD W, LAWRENCE
HATTON MD,LLOYD W, SALINA
HAUN MD,RUDY T, MANHATTAN
HAYEY MD,DAVID, WICHITA
HAWLEY MD,RAYMOND G, WICHITA
HAY MD,JAMES R, WICHITA
HAYES MD,J EDWARD, BOISE,ID
HAYES MD,KRIS A, HIAWATHA
HAYES MD,WILLIAM L, WICHITA
HAYNES MD,DEBORAH G, WICHITA
HAYS MD,THOMAS H, WICHITA
HEAD,OIANE E, KANSAS CITY
HEALY MD,PATRICK M, WICHITA
HEASTY MD,ROBERT G, MANHATTAN
HEBBAR MD,SATYA N, TOPEKA
HEDDEN MD,RICHARD J, CINCINNATI,OH
HEDEGAARD MD,CHERYL K, TOPEKA
HEDRICK MD,KENNETH E, HUTCHINSON
HEEB MD,CAMILLE S., TOPEKA
HEEB,JON J, KANSAS CITY
HEIN MD,DANIEL J, SALINA
HEINRICHS MD,DANIEL J, NEWTON
HEISLER MD,NORMAN T, SHAWNEE MISSION
HEIT MD,JOSEPH A, SHAWNEE MISSION
HELLMAN MD,DAVID W, WICHITA
HEMAYA MD,AMIR R, SHAWNEE MISSION
HENDRICKS MD,K DWIGHT, KANSAS CITY
HENDRICKS MD,WILLIAM J, PANAMA CITY,FL
HENNEY MD, JANE E, KANSAS CITY
HENNING JR MD,HAROLD J, MANHATTAN
HENNING MD,CALVIN W, OTTAWA
HENRY MD,JOSEPH E, SHAWNEE MISSION
HENRY,JEFFREY, SHAWNEE MISSION
HENSEL JR,JOHN M, SHAWNEE MISSION
HENWOOD MD,JOHN R, WICHITA
HERBEL MD,BRYON L, DURHAM,NC
HERBOLO MD,DAVID R., WICHITA
HERED MD,JOHN, WICHITA
HERMRECK MD,ARLO S, KANSAS CITY
HERNANDEZ,LISA M, KANSAS CITY,MO
HERRMAN MD,ADAM L, DODGE CITY
HERRON MD,KRISTINE G, OLATHE
HERSHBERGER DO., GROVER, WICHITA
HERSHORN MD,SIMON E, WICHITA
HESSE MD,JAMES F, WICHITA
HESSER MD,HERBERT H, SHAWNEE MISSION
HETT MD,EDWARD J, WICHITA
HETTINGER MD,MICHAEL E, SHAWNEE MISSION
HICKERT MD,MAUREEN C, INDIANAPOLIS,IN
HICKS JR MD,THOMAS E, EMPORIA
HIEBERT MD,DAVID L, LAWRENCE
HIEBERT MD,JOHN B, LAWRENCE
HIEBERT MD,JOHN M, KANSAS CITY
HIESTERMAN MD,HERMAN W, QUINTER
HIGGINBOTHAM MD,DENNIS G, GARDNER
HIGHTOWER MD,CURTIS E, WICHITA
HIGHTIGHT,JAMES E, SHAWNEE MISSION
HILD MD,PETER G, KANSAS CITY
HILGER,MARK A, KANSAS CITY
HILL MD,JAMES E, ARKANSAS CITY
HILL MD,LARY M, WICHITA
HILL MD,RICHARD H, MEADE
HILL MD,ROBERT N, TOPEKA
HILL MD,RODNEY W, SHAWNEE MISSION
HILLYER,JON F, KANSAS CITY
HILTON,KEVIN R, SHAWNEE MISSION
HINKIN MD,DOUGLAS P, MANHATTAN
HINSHAW JR MD,CHARLES T, WICHITA

HINSHAW MD,ALFRED H, WICHITA
HINSHAW,DARLA J, KANSAS CITY
HINTHORN MD,DANIEL R, KANSAS CITY
HINTON,ODNALD, KANSAS CITY
HIRATZKA MD,TDMIHARU, HIGH PDINT,NC
HIRSCHBERG MD,J COTTER, TOPEKA
HISZCZYNSKYJ MD,ROMAN, TOPEKA
HITCHCOCK MD,C THOMAS, SHAWNEE MISSION
HIZON MD,RAMON R, WICHITA
HD MD,SAMUEL, COFFEYVILLE
HOADLEY MD,WILLIAM D, KANSAS CITY
HOBBS MD,DONALD D, TOPEKA
HOBSON MD,MILBURN W, SHAWNEE MISSION
HOBUS MD,PAUL A, WICHITA
HODES MD,HERBERT C, SHAWNEE MISSION
HODGES MD,MERLE A, SALINA
HODGES MD,MERLE J, SALINA
HODGSON MD,DAVID K, WASHINGTON
HODSON MD,DON W, MARION
HODSON MD,HERVEY R, WICHITA
HOEHNE MD,TERRY G, SHAWNEE MISSION
HOFFER MD,JOHN G, RAYMORE,MO
HOFFMAN MD,J PHILIP, LAWRENCE
HOFFMANN MD,MARY A, LAWRENCE
HOLCOMB MD,WILLIAM M, LIBERAL
HOLDCRAFT MD,JACQUELYNE, KANSAS CITY
HOLDEN JR MD,RAYMOND F, WICHITA
HOLDERMAN MD,WALLACE D, HUTCHINSON
HOLLADAY MD,FRANK P, KANSAS CITY
HOLLADAY MD,KENNETH R, EUDORA
HOLLIS MD,KENNETH W, WICHITA
HOLLOWAY MD,KEVIN B, WICHITA
HOLMAN MD,JON B, SHAWNEE MISSION
HOLMES MD,FREDERICK F, KANSAS CITY
HOLMES MD,GRACE E, KANSAS CITY
HOLMES MD,JED, WICHITA
HOLMES MD,JOHN A, SHAWNEE MISSION
HOLMES MD,ROBERT W, TOPEKA
HOLSCHER MD,MARK R, PAOLA
HOLSINGER MD,DONALD M, PITTSBURG
HOLSTRUM MD,GAJEWSKI STACEY, ROANOKE,VA
HOLT MD,JOHN M, WICHITA
HOLT MD,ROBERT E, BELLEVILLE
HOOD MD,ROGER W, SHAWNEE MISSION
HOOPER MD,WILFORD D, HALSTEAD
HOOVER MD,LARRY A, KANSAS CITY
HOPKINS JR MD,B MORRISON, SCOTT CITY
HOPKINS MD,JAMES P, KANSAS CITY,MO
HOPKINS MD,LENLY, SHAWNEE MISSION
HOPKINS MD,WILLIAM O, SHAWNEE MISSION
HOPKINS,KATHY S, SHAWNEE MISSION
HOPPER MD,CHARLES R, EMPORIA
HOPPDCK MD,KEVIN C, WICHITA
HORBELT MD,DOUGLAS V, WICHITA
HORNBAKER MD,STANLEY D, CARBONDALE
HORNUNG MD,JOEL E, COUNCIL GROVE
HORSLEY MD,JAMES I, WICHITA
HORTON MD,GREG A, KANSAS CITY
HOSTETLER MD,ROBERT W, CINHARRON
HOSTETTER MD, M MORGAN, TOPEKA
HOSTETTER MD,JAMES P, TOPEKA
HOUGHTON MD,HOWARD L, KANSAS CITY
HOUSE MD,R E, SALINA
HOUSHOLDER MD,DANIEL FAIR, WICHITA
HOUSHOLDER MD,MARTHA S, WICHITA
HOUSTON II MD,LAWRENCE MORLEY, SHAWNEE MISSION
HOYDORCA,JOHN, SHAWNEE MISSION
HOWARD MD,DONALD O, WICHITA
HOWELL MD,BARBARA JOYCE, EMPORIA
HOWERTER JR MD,BERNARD E, COFFEYVILLE
HOYT MD,ARTHUR W, TOPEKA
HSU MD,CECILIA C, SHAWNEE MISSION
HSU MD,CHENG H, TOPEKA
HSU MD,SHIN-FU, TOPEKA
HUANG MD,JONSON, TOPEKA
HUDSON MD,ROBERT P, OLATHE
HUEBERT,KORY, WICHITA
HUEBNER MD,ROBERT STEPHAN, PITTSBURG
HUERTER MD,DAVID F, PITTSBURG
HUERTER MD,QUENTIN C, KANSAS CITY
HUGHES D O,STEVEN R, WICHITA
HUGHES MD,DOUGLAS W, KANSAS CITY
HUGHES MD,JOHN D, WICHITA
HUGHES MD,ROBERT W, LAWRENCE
HULTGREN MD,MYRON K, WICHITA
HUMMER MD,LLOYD M, WICHITA
HUMPHREY MD,MARK S, SHAWNEE MISSION
HUND MD,LARRY R, WICHITA
HUNKELER MD,JOHN D, KANSAS CITY,MO
HUNNINGHAKE MD,RONALD, WICHITA
HUNSBERGER D.O.,TERRY R, GARDEN CITY
HUNTER MD,VERDA J, KANSAS CITY
HUSEMAN MD,RICHARD ALLAN, SHAWNEE MISSION
HUSER,PAUL W, WICHITA
HUSTEAD MD,ROBERT F, WICHITA
HUSTON MD,FRANCIS W, WINCHESTER
HUSTON MD,JOSEPH W, TOPEKA
HUTCHINS MD,JOEL R, HOLTON
HUTCHINSON MD,DIRK T, SALINA
HUTCHINSON MD,STEVEN A, WICHITA
HUTCHISON MD,GLEN C, HAYS
HUTCHISON MD,JOE R, LEBOW
HUTCHISON MD,MICHAEL C, KANSAS CITY
HUTSEY MD,PAUL J, PONCA CITY,OK
HUTTON MD,FREDERICK A, TOPEKA
HUYCKE MD,EDWARD J, WICHITA
HWANG-HAMILTON,SHAN-SHAN, KANSAS CITY

HYDER MD,JACE W, WICHITA
HYLAND MD,JOSEPH M, TOPEKA
HYNES MD,HENRY E, WICHITA

IBARRA MD,J LUIS, WICHITA
IBARRA MD,RICHARD C, KANSAS CITY
ICHTERTZ MD,GREG L, WICHITA
IDBEIS MD,BADR, WICHITA
ILIFF MD,R DOUGLAS, TOPEKA
ILIDPDULDS MD,JOHN I, KANSAS CITY
ILDRETA MD,ALFREDO T, TOPEKA
IMSEIS MD,MIKHAIL Y, NESS CITY
INGHAM JR MD,H LAIRD, LAWRENCE
INGRAM MD,JOHN E, KANSAS CITY
INNES MD,ROBERT C, SHAWNEE MISSION
IRBY MD,PRATT, FORT SCOTT
ISAAC MD,CHARLES A, NEWTON
ISAAC,STEVEN R, WICHITA
ISAACS MD,JUANITA J, WICHITA
ISAACSON MD,RICHARD N, TOPEKA
ISERN MD,HENRY J, KANSAS CITY
ISNARD,DONNA M, GRANDVIEW,MO
ISSINGHOFF MD,CHAD J, HUTCHINSON
IWAY MD,BELIND D, ELKHART
IWAY MD,OLIVIA N, ELKHART

JABEL MD,JUVENAL T, SATANTA
JACKSON JR MD,DONALD H, TOPEKA
JACKSON MD,CHARLES R, WICHITA
JACKSON MD,MICHAEL D, GARDEN CITY
JACKSON MD,ROBERT V, SHAWNEE MISSION
JACKSON MD,THOMAS M, OLATHE
JACKSON MD,VICTOR L, ALTAMONT
JACKSON,MICHAEL R, WICHITA
JACKSON,ROBERT, KANSAS CITY
JACOB MD,KANNAMPALLY L, WICHITA
JACOB,SELA L, SHAWNEE MISSION
JACDBS MD,DAVID S, KANSAS CITY
JACDBS,TOMAYO S, KANSAS CITY
JACDBSON,ERIC, WICHITA
JACOBY II MD,ROBERT E, TOPEKA
JADHAV MD,KISHOR B, WICHITA
JAHANIAN MD,DARYOUSH, KANSAS CITY
JAMES MD,DONALD L, WICHITA
JAMES MD,PHILIP C, WICHITA
JAMES MD,DONALD R, SHAWNEE MISSION
JANSSEN MD,ERWIN T, TOPEKA
JANSSON MD,KENNETH A, WICHITA
JANTZ MD,JONATHAN W, NEWTON
JARROTT MD,JOHN B, HUTCHINSON
JASTER MD,PAUL J, HUTCHINSON
JATA,MARY A, KANSAS CITY,MO
JAYARAM MD,MARANDAPALLI R, KANSAS CITY
JEHAN MD,SAYED S, WICHITA
JENNEY MD,CHARLES B, WICHITA
JENSEN JR MD,JOHN T, WICHITA
JENSEN MD,DARAN L, WICHITA
JENSEN MD,ROBERT D, TOPEKA
JENSEN MD,THOMAS M, OLATHE
JERKOVICH MD,GEORGE S, SALINA
JETER MD,JOHN, SALINA
JEWELL MD,WILLIAM R, KANSAS CITY
JOACHIMS,BRIAN V, SHAWNEE MISSION
JOHANNING,JASON M, KANSAS CITY
JOHNSON MD,CAROL ANN, WICHITA
JOHNSON MD,CAROLYN K, WICHITA
JOHNSON MD,DAVID B, WICHITA
JOHNSON MD,DAVID B, KANSAS CITY
JOHNSON MD,GEORGE K, WICHITA
JOHNSON MD,HOWELL D, DODGE CITY
JOHNSON MD,J RICHARD, MCPHERSON
JOHNSON MD,JOHN C, SHAWNEE MISSION
JOHNSON MD,JOHN E, KANSAS CITY
JOHNSON MD,LINDA M, SHAWNEE MISSION
JOHNSON MD,MATTHEW S, WICHITA
JOHNSON MD,NADINE, "ANSAS CITY
JOHNSON MD,PAMELA M, SHAWNEE MISSION
JOHNSON MD,PAUL D, LEAVENWORTH
JOHNSON MD,RANDLE C, HUTCHINSON
JOHNSON MD,TERESA F, WINFIELD
JOHNSON MD,TERESA K, WICHITA
JOHNSON MD,THOMAS E, WICHITA
JOHNSON,BRIAN A, WICHITA
JOHNSON,MILLARD E, KIRKSVILLE,MO
JOHNSTON MD,SARAH C, WICHITA
JOHNSTON,VINCENT B, DES MOINES,IA
JONES JR MD,HERMAN H, KANSAS CITY
JONES MD,CHARLES E, SHAWNEE MISSION
JONES MD,CLIFTON C, TOPEKA
JONES MD,DAVID B, LARNED
JONES MD,EDWARD L, GREAT BEND
JONES MD,H IVOR, SHAWNEE MISSION
JONES MD,H PENFIELD, LAWRENCE

*Probationary members.

JDNES MD,JAY S, WICHITA
 JONES MD,JDN K, WICHITA
 JDNES MD,MICHAEL P, ATCHISON
 JONES MD,RODNEY, WICHITA
 JONES MD,WILLIAM T, MANHATTAN
 JONES,DAVIO K, DLATHE
 JONES,KELLY L, SHAWNEE MISSION
 JONG,CAROL N, KANSAS CITY
 JOSEPH JR MD,JAMES, WICHITA
 JOSEPH MD,BRIAN W, TOPEKA
 JOSEPH MD,HOWARD F, LAWRENCE
 JDSS MD,CHARLES S, TOPEKA
 JDST MD,GARY D, WICHITA
 JOYCE MD,G BERNARD, TOPEKA
 JUBAY JR MD,FELIPE L, LEOTI
 JUBELT MD,HILBERT P, MANHATTAN
 JUOD,KATHLEEN M, SHAWNEE MISSION
 JUDILLA JR MD,FRANCISCO, WICHITA
 JUSTUS MD,WILLIAM J, PLEASANTON

K

KADER MD,GIHAN S, WICHITA
 KADISON MD,HERBERT I, WICHITA
 KAHN MD,DAVID M, WICHITA
 KALDOR MD,RICHARD H, MANHATTAN
 KALIVAS MD,JAMES, KANSAS CITY
 KALIVAS MD,LINDA L, SHAWNEE MISSION
 KANE JR MD,WILLIAM M, HAYS
 KARDATZKE MD,DAVID S, WICHITA
 KARDATZKE MD,E STANLEY, WICHITA
 KARDATZKE MD,JON K, WICHITA
 KARLIN MD,CHARLES A, SHAWNEE MISSION
 KASHA MD,ROBERT L, WICHITA
 KASHYAP MD,BANSHI PRASAD, SHAWNEE MISSIO
 KASPER,MICHAEL L, KANSAS CITY
 KASSEBAUM MD,KENNETH G, WICHITA
 KASSELMAN,JEFFREY P, SHAWNEE MISSION
 KATER MD,ERIC D, WICHITA
 KATZ MD,ARNOLD L, SHAWNEE MISSION
 KATZ MD,DANIEL A, TOPEKA
 KATZ MD,FRED S, SHAWNEE MISSION
 KATZ MD,JEROME B, TOPEKA
 KAUSER MD,CURTIS D, KANSAS CITY
 KAUFFMAN,KURT A, KANSAS CITY
 KAUFFMAN MD,EUGENE E, WICHITA
 KAUFMAN MD,LELAND R, WINFIELD
 KAUFMAN MD,WILLARD E, MOUNDRIDGE
 KAUFMAN,LEONARD, KANSAS CITY
 KAUL MD,ANAND M, WINFIELD
 KAVEL MD,KARL K, TOPEKA
 KEARNS MD,NORBERT W, TOPEKA
 KEEVER,CRAIG E, TOPEKA
 KEISERMAN MD,WAYNE M, ODDGE CITY
 KEITGES MD,PIERRE W, KANSAS CITY,MO
 KEITH MD, REX B., WICHITA
 KELLER MD,JAMES P, WICHITA
 KELLER,JOHN W, WAKEENEY
 KELLERMAN MD,RICK, SALINA
 KELLEY MD,GORDON R, SHAWNEE MISSION
 KELLY O O,MARK A, PLAINVILLE
 KELLY MD,A CHRISTINE, HAYS
 KELLY MD,DAN A, TOPEKA
 KELLY MD,MICHELE, SHAWNEE MISSION
 KENAGY MD,ROBERT S, WICHITA
 KENOALL MD,TOM E, WICHITA
 KENORICK MD,J GILLERAN, WICHITA
 KENNALLY MD,KEVIN P, SABETHA
 KENNEDY MD,FREDERICK R, OLATHE
 KENNEDY MD,GERALD T, WICHITA
 KENNEDY MD,JENNIFER E, TOPEKA
 KENNEDY MD,L ELAINE, LAWRENCE
 KENNEDY MD,MICHAEL L, SHAWNEE MISSION
 KENNING MD,GERALD F, HUTCHINSON
 KENNY MD,LAURA M, SHAWNEE MISSION
 KENDYER MD,M RAY, ODDGE CITY
 KEPES MD,JOHN J, KANSAS CITY
 KERBY MD,GERALD R, KANSAS CITY
 KERR MD,GERALD F, FORT SCOTT
 KETCHUM MD,LYNN D, SHAWNEE MISSION
 KETTERMAN MD,DIANA K, WICHITA
 KEYES MD,MICHAEL J, WICHITA
 KEYS JR MD,ROBERT C, TOPEKA
 KHARE MD,PRATIBHA, KANSAS CITY
 KHICHA MD,GYANCHAND J, WICHITA
 KHOURY MD,GEDRGE H, WICHITA
 KHOURY,DANIEL J, WICHITA
 KHURANA MD,VIJAY K, WICHITA
 KIFER MD,C JAMES, HAYS
 KIHM MD,ALBERT A, CHANUTE
 KILGORE III MD,WILLIAM R, WICHITA
 KIM MD,JDNG M, KANSAS CITY
 KIM MD,PAIK N, WICHITA
 KIM MD,YONG W, TOPEKA
 KIM,CLEMENT, KANSAS CITY
 KIMBALL MD,RICHARD R, MANKATO
 KIMMEL MD,KENNETH K, HALSTEAD
 KIMPLE MD,KRIS G, WICHITA
 KINDEL MD,VICTORIA W, WICHITA

KINDLING MD,PAUL H, TOPEKA
 KINDREO MD,LYNN H, KANSAS CITY,MO
 KINDSCHER MD,JAMES D, KANSAS CITY
 KING MD,BRADLEY S, WICHITA
 KING MD,CHARLES R, KANSAS CITY
 KING MD,WILLIAM T, GREAT BEND
 KINGREY,DAVID A, KANSAS CITY
 KINPORTS SR MD,EDWARD B, KANSAS CITY,MO
 KIPPERMAN MD,ROBERT M, WICHITA
 KIRBY MD,MERLIN G, GREAT BEND
 KIRCHNER MD,FERNAND R, TUCSON,AZ
 KIRK JR MD,E DAVID, WICHITA
 KIRK MD,THOMAS E, MANHATTAN
 KIRKEGAARD MD,RDGER S, TOPEKA
 KIRSCH MD,MARK A, WICHITA
 KIRVEN,SHARDN D, KANSAS CITY
 KISER MD,JOHN L, WICHITA
 KISER MD,WILLARD J, WICHITA
 KISHORE MD,SHEELA, PARSONS
 KITCHEN MD,ROBERT R, WICHITA
 KITCHENS,TAMMY L, KANSAS CITY,MO
 KLAFTA MD,LEONARD A, WICHITA
 KLEIN MD,TERRY O, WICHITA
 KLEINHOLZ JR MD,EMIL JOHN, TOPEKA
 KLEINSASSER MD,WARREN L, DLATHE
 KLEMM MD,J MARTIN, KANSAS CITY,MO
 KLEMMER MD,HERBERT, TOPEKA
 KLEMDA JR MD,MARTIN B, BELDIT
 KLEWER MD,VERNON L, NEWTON
 KLINGLER JR MD,EUGENE A, MANHATTAN
 KLINGMAN MD,DIANE O, WICHITA
 KLOBASA MD,CHARLES L, MANHATTAN
 KLDNIS O O,DEMOSTHENIS, WICHITA
 KLDSTER,DANIEL R, KANSAS CITY,MO
 KLOSTERHOFF MD,BRUCE E, HUTCHINSON
 KLUMP MD,RICHARD, OLATHE
 KLUZAK MD,THOMAS R, WICHITA
 KNAPP MD,LESLIE E, WICHITA
 KNAPP MD,M ROBERT, WICHITA
 KNAPPENBERGER MD,KURT R, TOPEKA
 KNAPPENBERGER MD,ROY C, MANITOU SPRING,CO
 KNECHT MD,STEPHEN M, EMPORIA
 KNEIB,TIMOTHY G, KANSAS CITY
 KNEIDEL MD,THOMAS W, WICHITA
 KNIGHT MD,LAURA C, WICHITA
 KNIGHT MD,PHILIP J, WICHITA
 KNOX MD,JEFFREY B, SALINA
 KNDX,DOUGLAS B, SHAWNEE MISSION
 KNUDSEN MD, DENNIS, LIBERAL
 KNUDTSON,JOHN D, KANSAS CITY
 KNUTH MD,KENNETH L, INDEPENDENCE
 KODCH MD,KEVIN J, SHAWNEE MISSION
 KODANAZ MD,A AYTEKIN, SHAWNEE MISSION
 KOEHN MD,DANIEL J, INDEPENDENCE,MO
 KOEHN MD,NORMAN S, WICHITA
 KOELLIKER,LESLIE M, KANSAS CITY
 KOHLER,ULRIKE B, SHAWNEE MISSION
 KOKSAL MD,TOM, GARDEN CITY
 KOLSTE MD,BART K, OGALLALA,NE
 KOLSTE MD,REX J, COLBY
 KONIGSBERG JR MD,CHARLES, TOPEKA
 KODNS MD,JESS W, LIBERAL
 KOONTZ MD,JUDITH A, TOPEKA
 KOOSER MD,JUDITH A, TOPEKA
 KDRBER,DAVID E, SHAWNEE MISSION
 KORDONDWY MD,RAYMOND W, DRLAND,FL
 KDRTJE MD,DAVID K, WICHITA
 KDSSDY D D,ALLEN F, TOPEKA
 KOSTER,KIM R, SAN ANTONIO,TX
 KOURI MD,SAMMY H, WICHITA
 KOVAC MD,ANTHONY L, KANSAS CITY
 KOVARIK MD,ERNEST D, TOPEKA
 KOWALSKI MD,PETER C, TOPEKA
 KOWALSKI MD,STEPHEN F, TOPEKA
 KODZIKOWSKI MD,BEN M, SHAWNEE MISSION
 KRAKER MD,DAVID P, KANSAS CITY
 KRANTZ MD,KERMIT E, KANSAS CITY
 KRATZ MD,DONALD, WICHITA
 KRAUSE MD,ROLAND L, WICHITA
 KREADY MD,JOHN L, WICHITA
 KREHBIEL MD,MARK A, SALINA
 KRESIE MD,RANDALL J, TOPEKA
 KRETSINGER DD, W BROCK, EMPORIA
 KROLL MD,HARRY G, TOPEKA
 KRUCKMEYER MD,ALAN L, SALINA
 KRUEGER MD,KURT ALLEN, SHAWNEE MISSION
 KUBIN MD,DDRIS A, SHAWNEE MISSION
 KUBINA MD,GLENN RICHARD, WICHITA
 KUEBLER MD,KEVIN M, SHAWNEE MISSION
 KUETHER,TDOD A, KANSAS CITY
 KUHN MD,HENRY R, EL DORADO
 KUMAR MD,ARUN, WICHITA
 KUMAR MD,RENU, EMPORIA
 KUMAR MD,SURINDER, NEWTON
 KURTH MD,C JOSEPH, WICHITA
 KURTH MD,ROBERT H, SHAWNEE MISSION
 KWAPISZESKI,BRADLEY R, NORTHVILLE,MI
 KWEE MD,STOE T, KANSAS CITY
 KYI MD,WIN M, ODDGE CITY
 KYNER MD,JOSEPH L, KANSAS CITY

L

LACCHED MD,MICHAEL L, TOPEKA
 LAHAM MD,ALEXANDER J, DALLAS,TX

LAI MD,CHUEN-HUEY, WICHITA
 LAI MD,JENG Y, WICHITA
 LAI MD,MAX G, TOPEKA
 LAI,JOHN D, WICHITA
 LAING MD,ROBERT R, KANSAS CITY
 LAIRD MD,DALE D, OLATHE
 LAIBERT,JACQI I, SHAWNEE MISSION
 LANCE JR MD,JOHN F, WICHITA
 LANCE MD,RAYMOND W, PITTSBURG
 LANDAUER,KYLE H, KANSAS CITY
 LANG MD,CLAYTON A, TOPEKA
 LANGE MD,MICHAEL, LAWRENCE
 LAPI MD,ANGELD, SHAWNEE MISSION
 LAPI MD,RUTH M, SHAWNEE MISSION
 LARREA,PABLO J, KANSAS CITY
 LARSDN MD,DANUTA OKTAWIEC, SHAWNEE MISSION
 LARSDN MD,DELBERT L, HIAMATHA
 LARSDN,MELISSA L, SHAWNEE MISSION
 LASH MD,RAY E, SHAWNEE MISSION
 LASLEY MD,MICHAEL B, HAYS
 LASSETER MD,JAMES A, SALINA
 LATIMER MD,KATHERINE, WICHITA
 LAUDERT MD,SUSAN E, KANSAS CITY,MO
 LAUNEY MD,WALTON S, TOPEKA
 LAURY MD,DAVIO G, SAVANNAH,GA
 LAYA MD,CHRISTOPHER, PARSONS
 LAW MD,FINDLEY, ELLINWOOD
 LAWHORN MD,CHARLTON D, SHAWNEE MISSION
 LAWLESS MD,HAROLD L, BLUE RAPIDS
 LAWN MD,CLAUDIA A, WICHITA
 LAWN MD,RAYMONO A, WICHITA
 LAWRENCE MD,LINDA M, SALINA
 LAWRENCE MD,MICHAEL K, SALINA
 LAWS MD,LEWIS R, MARYSVILLE
 LAWS,NANCY J, WICHITA
 LAWSON MD,DWIGHT, N NAPLES,FL
 LAWHILL MD,THEODORE, KANSAS CITY
 LAYBOURNE JR MD,PAUL C, LAKE PLACIO,FL
 LE MD,CHUDNG OUC, GAROEN CITY
 LEAHY MD,JAMES D, SHAWNEE MISSION
 LEAR MD,REX V, WICHITA
 LEARNED MD,GEORGE R, LAWRENCE
 LEE JR MD,EDWARD S, WICHITA
 LEE MD, JAMES G, SHAWNEE MISSION
 LEE MD,JAE M, KANSAS CITY
 LEE MD,KYO R, KANSAS CITY
 LEE MD,MARTIN W, WICHITA
 LEE MD,R REX, WICHITA
 LEE MD,SONG DOW, TOPEKA
 LEE MD,SDNG PING, TOPEKA
 LEE MD,YONG U, EL OORADO
 LEESON,MICHAEL C, SHAWNEE MISSION
 LEFFLER MD,PAUL B, PITTSBURG
 LEGASPI JR MD,PEDRO L, SHAWNEE MISSION
 LEGER MD,LEE H, FT MYERS,FL
 LEHNERT,DARREN L, SHAWNEE MISSION
 LEHR,CARRIE WOODS, SHAWNEE MISSION
 LEIFER MD,WILLIAM N, TOPEKA
 LEIKER MD,JOSEPH, TOPEKA
 LEISY MD,JERALD W, WICHITA
 LEITCH MD,DAVID A, GARNETT
 LEITNER MD,VDAM B, WICHITA
 LEMOINE JR MD,ALBERT N, SHAWNEE MISSION
 LEMONS MD,STEPHEN F, ANDOVER
 LENEVE MD,ROBERT T, PERKINS,OK
 LENTZ MD,WILLIAM R, TOPEKA
 LED MD,WILLIAM A, SHAWNEE MISSION
 LEPSE MD,PETER S, TOPEKA
 LESKO MD,PAUL D, WICHITA
 LESSENDEN JR MD,C M, TOPEKA
 LESSER MD,DANE A, HUTCHINSON
 LESTER MD,JOHN BUCKLES, SHAWNEE MISSION
 LETOURNEAU MD,EDWARD N, OMAHA,NE
 LETTNER MD,HANS T, SCOTTSDALE,AZ
 LEU MD,RICHARD H, WICHITA
 LEVINE MD,ERROL, KANSAS CITY
 LEVINE MD,HOWARD T, SHAWNEE MISSION
 LEVINE MD,JOSEPH M, KANSAS CITY
 LEVINE MD,WILLIAM R, WICHITA
 LEVY MD,EDWIN Z, TOPEKA
 LEWIN MD,WALTER, SHAWNEE MISSION
 LEWIS,ANA L, KANSAS CITY
 LEWIS,E CHRISTOPHER, KANSAS CITY
 LIGHTY MD,OAN M, WICHITA
 LIEBERMAN MD,BRUCE IRWIN, KANSAS CITY
 LIES MD,RICHARD B, WICHITA
 LIESMANN MD,JEAN E, TOPEKA
 LILLICH MD,MAUREEN A, COLUMBIA,MO
 LIN MD,JOE J, WICHITA
 LIND II MD,EDWARD J, GODDARD
 LINDHOLM MD,DWIGHT L, WICHITA
 LINDHOLM MD,GERALD R, NEWTON
 LINDSLEY MD,CARL B, KANSAS CITY
 LINDSLEY MD,HERBERT B, KANSAS CITY
 LINHARDT MD,RONALD D, WICHITA
 LIPMAN MD,RANDEE E, WICHITA
 LIPSEY MD,JAMES H, SHAWNEE MISSION
 LISTERMAN MD,JOHN C, TOPEKA
 LITTELL MD,JAMES A, WICHITA
 LIU MD,ALBERT T, KANSAS CITY
 LIU MD,CHIEN, KANSAS CITY
 LIU,PENNY, LAWRENCE
 LIVINGSTON D.D.,DOUGLAS R, WICHITA
 LIVINGSTON MD,CHARLES E, SALINA
 LLDYD MD,JOHN C, EMPORIA
 LOCKE MD,MARLIN K, WAKEENEY
 LOCKE,KELLY T, ALTONA,WI
 LOCKWOOD MD,TED E, SHAWNEE MISSION

*Probationary members.

LOEFFLER MO,JAMES A, WICHITA
 LOEWEN MO,WILLIAM C, WICHITA
 LOGAN MO,WILLIAM S, TOPEKA
 LOGAN,ODNNA L, WICHITA
 LOGANBILL MO,VAROEN J, MOUNORIDGE
 LOHNES JR MO,JOHN H, WICHITA
 LOMASNEY MO,PATRICK J, HUTCHINSON
 LONEY MO,PAUL O, LOUISVILLE,KY
 LONG MO,EDWARD E, HUMBOLIT
 LONG MO,ROBERT C, NORTON
 LOPEZ,GRISSEL, KANSAS CITY
 LOPEZ,MARK O, KANSAS CITY
 LOPEZ,RUBEN J, KANSAS CITY
 LORENZETTI,LISA A, SHAWNEE MISSION
 LORTZ MO,PHILIP W, WICHITA
 LOSEE MO,JOHN M, WICHITA
 LOTUACO MO,GAMALIEL G, SHAWNEE MISSION
 LOVELANO MO,G CHARLES, LAWRENCE
 LOYETT MO,PAUL A, WICHITA
 LOW MO,HAROLD L, WICHITA
 LOWOEN,OWNE A, KANSAS CITY
 LOWE MO,STANLEY W, MANHATTAN
 LOWRY MO,PATRICK J, KANSAS CITY
 LUBETICH JR MO,JOHN F, SILVEROALE,WA
 LUCAS MO,GEORGE L, WICHITA
 LUCKEROTH MO,LEAH L, WICHITA
 LUOER,JACOB K, WICHITA
 LUOLOW MO,MICHAEL G, WICHITA
 LUEKEN MO,LUKE B, WICHITA
 LUETJE MO,CHARLES MARION, KANSAS CITY,MO
 LUI MO,NASON, TOPEKA
 LUJAN,CHARLES R, KANSAS CITY
 LUKERT MO,BARBARA P, KANSAS CITY
 LUNA MO,ANTHONY O, BUCKLIN
 LUNBERRY MO,JULIA J, COLUMBIA,MO
 LUNO MO, STEPHEN B, SHAWNEE MISSION
 LUNOAK,BRUCE E, KANSAS CITY
 LUNOQUEST MO,OAVIO E, HIAWATHA
 LUTZ MO,RICHARD E, WICHITA
 LYGRISSE MO,DAVID L, WICHITA
 LYNCH MO,OARYL A, OOOGE CITY
 LYNCH MO,JOHN A, TOPEKA
 LYNCH MO,MARY A, WICHITA
 LYNCH,GREGORY P, KANSAS CITY
 LYNE MO,ALAN W, ATCHISON
 LYONS JR MO,FRANK C, MANHATTAN

M

MABEN MO,PAMELA S, CHANUTE
 MAC KILLIP JR MO,DAVID L, WINFIELD
 MACARTHUR MO,RICHARD I, SHAWNEE MISSION
 MACOOGALL MO,MARGARET L, KANSAS CITY
 MACE MO,RONALD D, JUNCTION CITY
 MACE,RHONOA D, KANSAS CITY
 MACFARLANE MO,DOUGLAS B, OLATHE
 MACY MO,NORMAN E, SALINA
 MACY MO,TEO L, SALINA
 MAISON MO,WILLARD A, NORTONVILLE
 MADSEN MO,GLENN L, LAWRENCE
 MAGEE MO,LAWRENCE M, LAWRENCE
 MAGIDSON MO,ELLIOTT ARTHUR, WICHITA
 MAGSALIN MO,ROMULO O, HAYSVILLE
 MAILMAN MO,GERSHOM, WICHITA
 MALLONEE MO,WILLIAM M, HUTCHINSON
 MALLORY MO,JOHN A, SHAWNEE MISSION
 MALONE MO,OAVIO G, SHAWNEE MISSION
 MALONE MO,EUGENE M, HALSTEA
 MANAHAN MO,G EUGENE, LAWRENCE
 MANASCO MO,RONALD R, WICHITA
 MANDELBAUM MO,MARK A, WICHITA
 MANGUUGLU MO,ALI B, SALINA
 MANI MO,MANI M, KANSAS CITY
 MANN MO,JOHN B, HAYS
 MANNING MO,ROBERT T, WICHITA
 MANSUR MO,LISA I, WICHITA
 MANTZ MO,FRANK A, SHAWNEE MISSION
 MARBACH MO,JAMES C, WICHITA
 MARCELL MO,GERALD W, LYNOON
 MARCHBANKS MO,ODONALD L, SALINA
 MARINE MO,CLIFFORD S, OLATHE
 MARKESE,SABRINA, KANSAS CITY
 MARPLES MO,BRADLEY W, TOPEKA
 MARPLES MO,DOUGLAS, DOOGE CITY
 MARQUETTE,RAY J, KANSAS CITY
 MARSH MO,CONNIE M, WICHITA
 MARSH MO,HENRY O, WICHITA
 MARSHALL MO,GEORGE W, SALINA
 MARSHALL MO,ROBERT J, GAROEN CITY
 MARSO,STEVE P, KANSAS CITY,MO
 MARTIN JR MO,GLEN E, WICHITA
 MARTIN MO,JOSEPH P, KANSAS CITY
 MARTIN MO,MELANIE A, SHAWNEE MISSION
 MARTIN MO,NORMAN L, KANSAS CITY
 MARTIN MO,OLIVER L, SALINA
 MARTIN MO,RONALD L, WICHITA
 MARTIN MO,WILLIAM O, TOPEKA
 MARTINAK MO,JOSEPH F, TOPEKA
 MARTINSON MO,EDWARD E, KANSAS CITY
 MARVEL MO,JAMES EBBERT, ARKANSAS CITY

MARYMONT JR MO,JESSE H, WICHITA
 MASON MO,WAYNE E, INDEPENDENCE
 MASSIER,KIM M, SHAWNEE MISSION
 MASTERS MO,FRANCIS W, SHAWNEE MISSION
 MASTIO JR MO,GEORGE J, WICHITA
 MATASSARIN MO,BENJAMIN M, WICHITA
 MATASSARIN MO,FREDERICK W, WICHITA
 MATHEWS O O,THOMAS G, GAROEN CITY
 MATHEWS MO,DAVID R, KANSAS CITY,MO
 MATHEWS MO,ROBERT MAJOR, SHAWNEE MISSION
 MATHEWSON MO,HUGH S, KANSAS CITY
 MATLOCK MO,HARK S, HUTCHINSON
 MATTHEW MO,WILLIAM L, OLATHE
 MATTHEW,BRIAN, KANSAS CITY,MO
 MATTHEWS O O,GEORGE E, GARDEN CITY
 MATTHEWS MO,EARL H, SALINA
 MATTICK MO,IRVIN H, HAYS
 MATTIOLI MO,LEONE, KANSAS CITY
 MAUCK MO,HAROLD C, STOCKTON
 MAURICIO MO,DENNY G, WICHITA
 MAVEC MO,JAMES A, KANSAS CITY
 MAWDSLEY MO,MICHAEL W, WICHITA
 MAXFIELD MO,RUSSELL J, COLORADO SPRINGS,CO
 MAXWELL MO,GORDON E, SALINA
 MAXWELL MO,ROBERT A, SHAWNEE MISSION
 MAY MO,KENNETH L, BONNER SPRINGS
 MAY,LANCE A, KANSAS CITY
 MAYS,KEVIN P, WICHITA
 MC FARLANO MO,GRETA S, CHANUTE
 MCALLASTER MO,CLAUDIA, LEAVENWORTH
 MCALLASTER MO,WENOALE E, GREAT BEND
 MCANELY MO,ROBERT O, KANSAS CITY
 MCATEE,JAMES R, SHAWNEE MISSION
 MCBOYLE MO,MARILEE, WICHITA
 MCCANN MO,PATRICK E, FORT SCOTT
 MCCANN MO,WILLIAM E, OLATHE
 MCCARTER MO,OUANE K, TOPEKA
 MCCARTHY MO,AILEEN C, TOPEKA
 MCCARTHY MO,ROBERT P, KANSAS CITY
 MCCAUGHEY MO,HUGH W, SHAWNEE MISSION
 MCCAULEY,ROBERT L, KANSAS CITY
 MCCLAIN MO,STEVE A, SHAWNEE MISSION
 MCCLANAHAN MO,WARD A, WICHITA
 MCCELLAN MO,ERNEST L, WICHITA
 MCCOLLUM MO,WILLIAM B, LEAVENWORTH
 MCCOMAS JR MO,MARMADUKE D, TOPEKA
 MCCORMICK MO,EUGENE CARL, WELLINGTON
 MCCOWEN MO,HERBERT M, SHAWNEE MISSION
 MCCOWN MO,ROBERT B, NEWTON
 MCCOY MO,C PATRICK, WICHITA
 MCCOY MO,CHARLES P, WICHITA
 MCCOY MO,CHARLES T, HUTCHINSON
 MCCOY MO,MICHAEL T, TOPEKA
 MCCRAE MO,SPENCER C, SALINA
 MCCULLOCH MO,OWANA L, KANSAS CITY
 MCCUNE MO,MARK A, SHAWNEE MISSION
 MCOANIEL MO,R JAMES, PITTSBURG
 MCOONALO MO,KEVIN R, HAYS
 MCOONALO MO,THOMAS L, HAYS
 MCOONOUGH MO,W OAVIO, WICHITA
 MCOOWELL,CHARLES S, SHAWNEE MISSION
 MCOOWELL,KATHLEEN L, KANSAS CITY
 MCEACHEN MO,WILLIAM H, SHAWNEE MISSION
 MCELHINNEY MO,CHARLES F, OOOGE CITY
 MCELROY MO,ROBERT T, TOPEKA
 MCELROY MO,WILBUR J, CNTRL AFRICAN REPUB.
 MCGEENEY MO,TERRY L, SENECA
 MCGINNESS MO,MARILEE K, LAWRENCE
 MCGRATH MO,BARBARA A, SHAWNEE MISSION
 MCGUIRE MO,THOMAS H, SHAWNEE MISSION
 MCGUIRE MO,WILLIAM F, WICHITA
 MCGUIRE,CHARLES W, WICHITA
 MCINNIS MO,DALETON B, WICHITA
 MCKAY MO,ROBERT S, WICHITA
 MCKENNA MO,MICHAEL J, FORT SCOTT
 MCKERRACHER MO,ROBERT O, MULVANE
 MCKINNEY O O,SHARON L, TOPEKA
 MCKITTRICK MO,RICHARD, SHAWNEE MISSION
 MCCLAIN MO,KENNETH, RANSOM
 MCMASTER MO, JOHN F, WICHITA
 MCMILLAN MO,JOHN M, OOOGE CITY
 MCMULLEN MO,BRUCE R, WICHITA
 MCMULLEN MO,JOSEPH E, HUTCHINSON
 MCMURRAY MO,LAURA J, SHAWNEE MISSION
 MCNEIL MO,ELBERT O, MANHATTAN
 MCNICKLE MO,GEORGE A, WICHITA
 MCQUEEN MO,OAVIO ARNOLO, WICHITA
 MCRAE-OENNING MO,PATRICIA, LAWRENCE
 MEADOR O O,RICHARD W, MEDICINE LOOGE
 MEANS MO,MILA LEE, WICHITA
 MEBUST MO,WINSTON K, KANSAS CITY
 MEOUNA MO,LEO L, LINCOLN
 MEEK JR MO,JOSEPH C, WICHITA
 MEEK MO,PALMER F, MANHATTAN
 MEEKER II MO,BRUCE P, WICHITA
 MEEKS, MARK A, GAROEN CITY
 MEIOINGER MO,RAY, HIAWATHA
 MEIOINGER MO,RICHARD, TOPEKA
 MEIER MO,MICHAEL S, WICHITA
 MEIER MO,PATRICIA A, VACAVILLE,CA
 MEIER,MICHAEL M, KANSAS CITY
 MEISEL JR MO,RICHARD L, WICHITA
 MELEAN MO,JAIME, WICHITA
 MELHAM MO,THOMAS J, NUNCIE,IN
 MELHORN MO,J MARK, WICHITA
 MELHORN MO,KATHERINE J, WICHITA
 MELIN MO,BRUCE O, GAROEN CITY
 MENAKER MO,JEROME S, WICHITA
 MENOIOLA MO,AMBROSIO P, PITTSBURG

MENDIONES MO,L MARLENE, WICHITA
 MENDLICK MO,R MICHAEL, OLATHE
 MENEHAN MO,H JAMES, WICHITA
 MENGEL MO,CHARLES E, LEAVENWORTH
 MENKING MO,F W MANFRED, WICHITA
 MENKING MO,SUSAN MARGARET, WICHITA
 MENNINGER MO,BRENT O, TOPEKA
 MENNINGER MO,ROBERT G, TOPEKA
 MENNINGER MO,ROY W, TOPEKA
 MENNINGER MO,W WALTER, TOPEKA
 MENON MO,REMA, PARSONS
 MENZEL MO,THOMAS E, SENECA
 MERCADER MO,MARIO S, WICHITA
 MERCOITH MO,W TOM, WICHITA
 MERKEL MO,EARL O, RUSSELL
 MERRIFIELD MO,TERRY S, WICHITA
 MERRITT MO,GREGORY A, KANSAS CITY
 MERRITT MO,W HENRY, LEAVENWORTH
 MERSHON MO,JAMES C, WICHITA
 MESSAMORE MO,OEBA L, WICHITA
 MESSNER MO,STAN A, WICHITA
 MEYER MO,MARK C, SHAWNEE MISSION
 MEYER MO,O WARREN, TOPEKA
 MEYER MO,WARREN E, WICHITA
 MEYER,ANGELA M, WICHITA
 MEYERS MO,STEPHEN, GARDEN CITY
 MHATRE MO,VIJAY R, TOPEKA
 MICHELBACH MO,ALBERT P, WICHITA
 MIGLIAZZO MO,CARL V, SHAWNEE MISSION
 MIGUELINO MO,OLIVER M, EMPORIA
 MILES,WILLIAM S, SHAWNEE MISSION
 MILFELD MO,DOUGLAS J, WICHITA
 MILLER O O,STEPHEN A, COFFEYVILLE
 MILLER MO,DAVID PATERSON, WICHITA
 MILLER MO,DEAN M, PARSONS
 MILLER MO,DENNIS W, KANSAS CITY
 MILLER MO,DOON E, TAMPA,FL
 MILLER MO,EARL E, PITTSBURG
 MILLER MO,ELOEN V, SALINA
 MILLER MO,FRANKLIN R, WINFIELD
 MILLER MO,FREEMAN LANCE, SHAWNEE MISSION
 MILLER MO,HERBERT C, NORFORD,CT
 MILLER MO,KEVIN E, LAFAYETTE,IN
 MILLER MO,ROBERT E, GAROEN CITY
 MILLER MO,ROGER M, WICHITA
 MILLER MO,STEPHEN FRANCIS, PARSONS
 MILLER MO,TODO A, WICHITA
 MILLER,KYLE A, SHAWNEE MISSION
 MILLIGAN MO,ODONALD B, KANSAS CITY
 MILLS JR MO,PHILIP E, TOPEKA
 MILLS MO,CHARLES O, WICHITA
 MILLS MO,CRAIG G, KANSAS CITY
 MILLS MO,PHILIP R, WICHITA
 MILLS MO,STEPHEN C, HUTCHINSON
 MILLS MO,VERNON A, LEAVENWORTH
 MIMIAGA,ANNE T, WICHITA
 MINGES MO,TIMOTHY J, WESTMORELAND
 MINGLE MO,RALPH R, SHAWNEE MISSION
 MINNS MO,GAROLD O, WICHITA
 MIRANO MO,JOSEPH R, WICHITA
 MISKE MO,STEPHAINE A, TOPEKA
 MISKEW MO,DOON B, SHAWNEE MISSION
 MITCHELL MO,ALEX C, LAWRENCE
 MOORELL MO,CAROL A, LAWRENCE
 MOORELL MO,ELLEN M, SHAWNEE MISSION
 MOOLIN MO,HERBERT C, TOPEKA
 MOELLER MO,CHRISTOPHER A, WICHITA
 MOELLER MO,ODONALD D, KANSAS CITY
 MOFFAT MO,ROBERT E, SHAWNEE MISSION
 MOHLER MO,JACK M, ABILENE
 MOLOS MO,MARK A, KANSAS CITY
 MONSOUR MO,JAMES W, OENVER,CO
 MONTERO JR MO,CARLOS, MIAMI,FL
 MONTGOMERY MO,MICHAEL L, EMPORIA
 MONTGOMERYSHORT MO,RUTH G, WICHITA
 MOORE MO,DENNIS F, WICHITA
 MOORE MO,JAMES E, NEWTON
 MOORE MO,ROBERT, HOISINGTON
 MOORE MO,ROBERT F, CANEY
 MOORE MO,WAYNE V, KANSAS CITY
 MOORHEAD JR MO,F ALLEN, NEOESHA
 MORALES JR,OSCAR, KANSAS CITY
 MORAN MO,JOHN FREDERICK, KANSAS CITY
 MOREANO,PHILLIP A., KANSAS CITY
 MORFFI MO,RAUL R, KANSAS CITY
 MORGAN II MO,OAVIO LLOYD, OLATHE
 MORGAN III MO,LOUIS S, WICHITA
 MORGAN MO,OICK A, WICHITA
 MORGAN MO,JAMES I, WICHITA
 MORGAN MO,MITCH A, WICHITA
 MORGAN MO,RANDALL J, WICHITA
 MORGAN MO,SCOTT, NEWTON
 MORITZ MO,RICK S, SHAWNEE MISSION
 MORONEY MO,JEAN M, SHAWNEE MISSION
 MORRIS MO,MERLE O, TOPEKA
 MORRIS,JENNIFER A, KANSAS CITY
 MORRISON MO,GRACE A, TOPEKA
 MORRISON MO,IRA R, ATCHISON
 MORRISON MO,MICHAEL R, TOPEKA
 MORRISON MO,RICHARD L, WICHITA
 MORROW MO,THOMAS F, WICHITA
 MORTON MO,ROBERT A, ARKANSAS CITY
 MOSELEY,A CANOACE, KANSAS CITY,MO
 MOSER JR MO,ROBERT P, TRIBUNE
 MOSER MO,SCOTT E, WICHITA
 MOSIER MO,KEVIN M, PARSONS
 MOSIER MO,STANLEY JAY, WICHITA
 MOSIER MO,STEVEN J, MANHATTAN
 MOSSINGHOFF,OEBOHRA GRIESER, SHAWNEE MISSION

*Probationary members.

MDWERT MD, WILLIAM E, SALINA
 MOWRY MD, GERALD L, MANHATTAN
 MRDZ MD, MARY K, WICHITA
 MUEHLBERGER MD, JAMES J, SHAWNEE MISSION
 MUELLER MD, ARNOLD V, TOPEKA
 MUELLER MD, MICHAEL A, WICHITA
 MUETH CDUPLAND MD, JOAN D, WICHITA
 MUILENBURG, JEFFREY, WICHITA
 MULL MD, JOHN C, HUTCHINSON
 MULLER MD, SAMUEL B, PITTSBURG
 MULLIGAN, LINDA L, SHAWNEE MISSION
 MULLINIX MD, JANICE M, WICHITA
 MULLINS MD, JOHN R, WICHITA
 MUNNS MD, STEPHEN W, KANSAS CITY
 MURFITT MD, MALCOLM C, LINDSBURG
 MURPHY MD, BARRY L, WICHITA
 MURPHY MD, DUANE A, WICHITA
 MURPHY MD, JAY W, SHAWNEE MISSION
 MURPHY MD, MICHAEL, TOPEKA
 MURPHY MD, PATRICK L, WICHITA
 MURPHY MD, PAUL M, WICHITA
 MURPHY MD, PAUL W, WICHITA
 MURPHY MD, ROBERT M, KANSAS CITY
 MURPHY MD, WILLIAM R, SHAWNEE MISSION
 MURPHY MD, WILLIAM R C, WICHITA
 MURPHY, TRACY O, KANSAS CITY
 MURRAY MD, JANE L, KANSAS CITY
 MURRAY MD, KENT B, WICHITA
 MURRAY MD, W LEE, SHAWNEE MISSION
 MURRAY MD, RICHARD W, WICHITA
 MUSE MD, ROGER K, OATTON, OH
 MYERS IV MD, PERCY C, TOPEKA
 MYERS JR MD, EARL B, INDEPENDENCE
 MYERS MD, DANIEL L, CONCORDIA
 MYERS MD, JOE ANN, TOPEKA
 MYRICK MD, MICKEY C, HAYS
 MYRICK MD, STEPHEN W, LAWRENCE

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NABDURS MD, RICHARD D, TOPEKA
 NACHTIGALL MD, ANDREW, NEWTON
 NAGARAJU MD, ARAMARAJU, EMPORIA
 NALDOZA JR MD, FAUSTINO M, WELLINGTON
 NAMMUM MD, PETER A, KANSAS CITY
 NANNEY MD, GREGORY O, HUTCHINSON
 NARCISO MD, VICENTE D, ABILENE
 NARRO MD, JOHN P, SHAWNEE MISSION
 NASH MD, CYNTHIA I, WICHITA
 NASH MD, ROBERT A, SHAWNEE MISSION
 NASSERI, KEVIN K, KANSAS CITY
 NATHAN MD, WILLIAM A, TOPEKA
 NAUER MD, PAULA LDU, SHAWNEE MISSION
 NAVICKAS MD, LEDNARO A, SHAWNEE MISSION
 NAZARIO MD, LILIANA E, SHAWNEE MISSION
 NEEF MD, ODUG STEVENS, HUMBOLDT
 NEHRAYAN, MARC L, ENCINO, CA
 NEIBURGER MD, JAMES B, SHAWNEE MISSION
 NEIGHBOR MD, ERNEST H, SHAWNEE MISSION
 NEIL MD, ROY N, HAYS
 NELLIS MD, STEPHANIE F, WICHITA
 NELSON JR MD, GUST H, WICHITA
 NELSON MD, BRYAN C, SHAWNEE MISSION
 NELSON MD, CHARLES G, ODOGE CITY
 NELSON MD, DOUGLAS LERDY, SALINA
 NELSON MD, GERALD O, WICHITA
 NELSON MD, JOHN B, KANSAS CITY
 NELSON MD, MARIAN K, SALINA
 NELSON MD, RICHARD D, LAWRENCE
 NELSON MD, RUSSELL ALAN, WICHITA
 NELSON MD, T EUGENE, FORT SCOTT
 NELSON, JANET M, SHAWNEE MISSION
 NELSON, TAMMIE L, DLAHE
 NESMITH MD, LESLIE W, WICHITA
 NETHERTON MD, OAVIO M, WICHITA
 NEUBAUER MD, MARCUS A, SHAWNEE MISSION
 NEUENSCHWANDER MD, JOHN, HDXIE
 NEUENSCHWANDER MD, JOHN RAND, HDXIE
 NEUER MD, FREDERICK S, EMPORIA
 NEUHAUS, JOHN P, WICHITA
 NEUMANN MD, JAMES W, SALINA
 NEUSCHAFER MD, DARREL R, HUTCHINSON
 NEVINS MD, RICHARD L, LIBERAL
 NEWBY MD, JAMES P, WICHITA
 NEWBY, CDRY, KANSAS CITY
 NEWCOMB MD, WARD M, HAYS
 NEWELL, LINDA C, SHAWNEE MISSION
 NEWSOM MD, F CARTER, WICHITA
 NGUYEN, Z CHAT, WICHITA
 NIBBELINK MD, LARRY WAYNE, KANSAS CITY
 NICE MD, G WILLIAM, TOPEKA
 NICHOLS MD, JON C, SHAWNEE MISSION
 NICHOLS MD, ROBERT R, FORT SCOTT
 NICKELL MD, WENDELL K, SALINA
 NIEDEREE MD, DAVID W, DERBY
 NIELSEN MD, MARY L, WICHITA
 NIENSTEDT MD, JOHN F, SUN CITY, AZ
 HIGH MD, STEPHEN S, CHESAPEAKE, VA
 NIGHTENGALE MD, DIANE D, EL DORADO
 NIKNIA MD, MORTOZA, GARDNER

NISLY MD, JANA L, WICHITA
 NIXON JR, NED R, SHAWNEE MISSION
 NIXON MD, JAMES E, DODGE CITY
 NIXON MD, RICHARD A, SALINA
 NIXON MD, WILLIAM A, WICHITA
 NDBLE MD, MARK J, KANSAS CITY
 NDLA, BOUNSAYATH, WICHITA
 NDLKER, STEPHEN G, LAWSON, MD
 NDLLA MD, LDRAINE B, WICHITA
 NDDRDHDEK MD, LYLE J, HAYS
 NDRMAN MD, BENJAMIN R, WICHITA
 NORRIS MD, CHARLEY W, KANSAS CITY
 NORRIS MD, ROBERT P, WICHITA
 NORTH MD, DORIS G, WICHITA
 NORTHWAY MD, DANIEL P, TOPEKA
 NORTON MD, KENNETH A, SHAWNEE MISSION
 NORTON MD, ROBERT K, WICHITA
 NSTI MD, JUAN C, SHAWNEE MISSION
 NOTHNAGEL MD, ARNOLD F, SHAWNEE MISSION
 NOTTINGHAM MD, ROBERT M, DLAHE
 NOVDTNY MD, PETER C, TOPEKA
 NULL MD, WILLIAM G, SALINA
 NUNEMAKER MD, MARION E, HUTCHINSON
 NUNLEY, PIERCE O, SHREVEPORT, LA
 NYBERG MD, FREDRIK F, TOWANDA
 NYE MD, C ERIK, SHAWNEE MISSION

O

O'BOYNICK II MD, PAUL LEONARD, KANSAS CITY
 O'BRYAN MD, JAMES J, SHAWNEE MISSION
 O'CALLAGHAN MD, WILLIAM K, TOPEKA
 O'CELL MD, MICHAEL L, KANSAS CITY
 O'DONNELL JR MD, LEDNARO A, WICHITA
 O'DONNELL MD, HARRY E, JUNCTION CITY
 O'DONNELL MD, JANET E, PHOENIX, AZ
 O'NEAL MD, LYNN W, LAWRENCE
 O'NEIL MD, ROBERT H, TOPEKA
 OGDURN MD, ROBERT L, TOPEKA
 OCHSNER MD, BRUCE B, WICHITA
 ODENHEIMER MD, BURTRAM J, WICHITA
 ODGERS MD, RODNEY K, PITTSBURG
 ODDM MD, DANIEL G, HAYS
 OEHME MD, STEPHEN F, FAYETTEVILLE, NC
 OELSCHLAGER MD, RONALD D, LAWRENCE
 OHMAN MD, RICHARD J, DODGE CITY
 OHMART MD, RICHARD V, DAKLEY
 OLM MD, JERRY L, KANSAS CITY
 OLMSTEAD MD, CALVIN G, WICHITA
 OLNEY MD, BRAD W, KANSAS CITY
 OLNEY MD, ROBERT O, MANHATTAN
 OLSEN MD, PHILLIP S, EL DORADO
 OLSON MD, NANCY Y, KANSAS CITY
 OLSON MD, DAN E, WICHITA
 OLSON MD, ERWIN T, NEWTON
 OLSON MD, THOMAS H, SHAWNEE MISSION
 OLSON, INGER L, INDIANAPOLIS, IN
 OPENSHAW MD, CALVIN R, HUTCHINSON
 OPPLIGER MD, ERIC R, GARDEN CITY
 ORCHARO MD, RICHARD A, LAWRENCE
 ORLANDO III MD, JAMES, CONCORDIA
 ORTH-BAAHMAN MD, OLANE M, WICHITA
 ORTH, GREGORY, WICHITA
 OSBERN MD, LLOA, LAWRENCE
 OSBORNE MD, CONRAD C, WICHITA
 OSID MD, ANTONIO L, WICHITA
 OSDBA MD, WILLIAM G, WICHITA
 USTER MD, JOYCE A, WICHITA
 OTTINGER MD, CHRISTOPHER M, SHAWNEE MISSION
 OQUAND JR MD, BIBIAN B, WICHITA
 OVERFIELD MD, A SCOTT, KANSAS CITY
 OWEN III MD, JAMES W, TOPEKA
 OWEN MD, LARUE W, WICHITA
 OWEN MD, PERE A, WICHITA
 OWENS JR MD, WILLIAM S, COLUMBIA, SC
 OWENS MD, DAVID B, SHAWNEE MISSION
 OXLER JR MD, JOHN EDWARD, SHAWNEE MISSION
 OXLEY MD, OWIGHT K, WICHITA
 DYER MD, FREDERICK R, HUTCHINSON

P

PAGE O O, LESLIE F, FORT SCOTT
 PAGE MD, RUTH, WICHITA
 PAI MD, RADHA Y, PARSONS
 PAI MD, VARADARAJ S, PARSONS
 PALAGANAS-TOSCO MD, AMANDA C, MCLDUTH
 PALKO MD, WILLIAM M, WICHITA
 PALMBERG MD, KENT E, TOPEKA
 PALMER MD, DAVID L, WICHITA
 PALMER MD, GERALD K, SALINA
 PALMER MD, H C, LIBERAL
 PALMER MD, MARVIN M, LEAVENWORTH
 PALTAN JR MD, JOSE D, WICHITA
 PANKOW MD, KIMBERLY J, WICHITA
 PANKOW MD, LARRY M, WICHITA
 PAPP JR MD, S DEAN, PITTSBURG
 PARANDJITH MD, SUBRAMANIAM P, PARSONS

PARDD MD, LILLIAN G, KANSAS CITY
 PARDD MD, MANUEL P, KANSAS CITY
 PAREKH MD, AJITKUMAR M, KANSAS CITY
 PAREKH MD, MADHAVI A, KANSAS CITY
 PARHAM MD, VERDON W, CHANUTE
 PARK, RACHAEL E, KANSAS CITY
 PARKER MD, HAROLD L, WICHITA
 PARKS MD, DOUGLAS S, SYRACUSE
 PARKS MD, JON C, WICHITA
 PARMAN MD, CRAIG R, WICHITA
 PARMAN MD, ROBERT D, TOPEKA
 PARMAN, LINDA M, SHAWNEE MISSION
 PARR JR MD, HAROLD E, TOPEKA
 PARR MD, CATHERINE, SHAWNEE MISSION
 PARRA MD, DANIEL C, KANSAS CITY
 PARRA MD, MIGUEL D, KANSAS CITY
 PARRIS MD, ROGER D, FORT SCOTT
 PARRISH JR, DAVID L, SHAWNEE MISSION
 PARRISH, LISA K, WICHITA
 PARSA, MICHAEL B, KANSAS CITY
 PARSI MD, MANUTCHEHR, PITTSBURG
 PARULKAR MD, DEEPAK S, TOPEKA
 PASCUA MD, PERCIVAL G, TOPEKA
 PASSMAN MD, STEVEN M, WICHITA
 PASTOR MD, VICTOR HUGO, EMPORIA
 PATEL MD, MAHENDRA N, TOPEKA
 PATEL MD, VINOD, TOPEKA
 PATRICK MD, FRED EDWARD, TOPEKA
 PATRON MD, RICARDO A, LIBERAL
 PATRON, ROBERT R, KANSAS CITY
 PATTERSON MD, JOHN R, SHAWNEE MISSION
 PATTON MD, J MICHAEL, WICHITA
 PAULS MD, DANIEL N, PARSONS
 PAULS MD, DAVID G, WICHITA
 PAULY MD, TIMOTHY R, PRATT
 PAXTON MD, EDWARD SCOTT, WICHITA
 PAY MD, NORMAN T, WICHITA
 PAYNE MD, J RALPH, KANSAS CITY, MD
 PAYNE MD, ROBERT R, TOPEKA
 PAZELL MD, JOHN A, SHAWNEE MISSION
 PEARCE MD, LUNETTA M, SHAWNEE MISSION
 PEASE MD, GARY L, HUTCHINSON
 PECK MD, ROGER, GREAT BEND
 PEDERSON MD, ARNOLD M, PLAINVILLE
 PEORAZA MD, HERNANDO, WELLINGTON
 PEERY MD, WILLIAM H, WICHITA
 PEES JR MD, GERALD B, LAWRENCE
 PEES MD, GERALD B, APOLLO BEACH, FL
 PEEFLY MD, ELMER D, CHETOPA
 PEIL MD, MICHAEL L, WICHITA
 PELLETIER JR MD, LAWRENCE L, WICHITA
 PENCE MD, CHARLES D, WICHITA
 PENNER MD, STEVEN D, WICHITA
 PENNER MD, TIMOTHY M, CLAY CENTER
 PENNINGTON MD, KATHERINE, WICHITA
 PENNINGTON MD, PHILIP A, KANSAS CITY
 PENTECOST MD, RICHARD L, SHAWNEE MISSION
 PENZLER MD, CINDY E, TOPEKA
 PERALES MD, MERCEDES, WICHITA
 PERDUE II MD, W LANG, TOPEKA
 PEREIRA MD, WILLY G, ARKANSAS CITY
 PEREZ-TAMAYO MD, CLAUDIA, SALINA
 PERIDD MD, DOMINADOR T, ELKHART
 PERKINS MD, JACK L, HUTCHINSON
 PERRY JR MD, LAWRENCE L, KANSAS CITY
 PERSONS MD, OLANE L, ROCHESTER, MN
 PETELIN MD, JOSEPH B, SHAWNEE MISSION
 PETERIE MD, JERRY O, WICHITA
 PETERS MD, THOMAS J, WICHITA
 PETERS MD, TIMOTHY R, WICHITA
 PETERSEN MD, GERALD D, SHAWNEE MISSION
 PETERSEN, MARK J, BONNER SPRING
 PETERSON O D, PEGGY S, MANHATTAN
 PETERSON JR MD, EVAN A, WATHENA
 PETERSON JR MD, JACK T, MANHATTAN
 PETERSON MD, HUBERT C, LIBERAL
 PETERSON MD, JACK T, MANHATTAN
 PETERSON MD, JAMES E, SALINA
 PETERSON MD, ROBERT L, TOPEKA
 PETERSON MD, STEPHEN E, TOPEKA
 PETERSON MD, VERNON J, TOPEKA
 PETRIK MD, EDWIN L, TOPEKA
 PETTAVEL, PAUL P, SHAWNEE MISSION
 PETTERSON MD, CECIL E, SYRACUSE
 PETTERSON MD, DENNIS CRAIG, TOPEKA
 PETTERSON MD, D RUTH S, RIDGEVILLE, IN
 PETTIOHN MD, WALTER J, GUADALAJARA JALISCO, MX
 PFEIFER II, F MICHAEL, KANSAS CITY
 PFEIFFER, BRIAN D, KANSAS CITY
 PFUETZE MD, BRUCE L, SHAWNEE MISSION
 PFUETZE MD, KARL D, SHAWNEE MISSION
 PFUETZE MD, ROBERT E, TOPEKA
 PHELPS MD, DAVID WAYNE, FORT SCOTT
 PHILLIPP MD, JOSEPH THEODORE, MANHATTAN
 PHILLIPS MD, DENNIS G, WICHITA
 PHILLIPS MD, WARREN G, SHAWNEE MISSION
 PHIPPS MD, CARLA B, LAWRENCE
 PHIPPS MD, JACK G, WICHITA
 PHIPPS MD, RONNY, INDEPENDENCE
 PIBURN MD, MARVIN F, WICHITA
 PICKERT MD, CURTIS B, WICHITA
 PIERCE MD, CHARLES F, TOPEKA
 PIERCE MD, DONALD R, TOPEKA
 PIERCE MD, GEORGE E, KANSAS CITY
 PIERSON MD, MARK E, EMPORIA
 PIERSON MD, WEIR, MCPherson
 PILCHARD MD, WILLIAM A, SHAWNEE MISSION
 PINGLETON MD, WILLIAM W, SHAWNEE MISSION
 PINKHAM MD, CHRIS M, KANSAS CITY, MD
 PINSKER MD, JACOB A, WICHITA

*Probationary members.

PIPPIN MD,LYNNE K, SHAWNEE MISSION
PITTS MD,RONALD L, SHAWNEE MISSION
PITTS,JEANETTE M, KANSAS CITY
PLACEK MD,DEBRA C, LAWRENCE
PLAYAC MD,THOMAS, WICHITA
PLUMB MD,RENNE L, KANSAS CITY
PDRREBARAC MD,FRANCIS A, WICHITA
PDRREBARAC,PIERRE, ATLANTA,GA
PDGSON MD,GEORGE W, PITTSBURG
POKORNY MD,JOHN C, CINCINNATI,OH
POLINER MD,LAWRENCE R, WICHITA
POLING MD,TERRY L, WICHITA
POLLACK MD,SIMON, PORTLAND,OR
POLLMAN MD,STANLEY E, WICHITA
POLLOCK MD,ANTHONY G A, WICHITA
POLLY MD,RICHARD E, TOPEKA
POLSON MD,ROBERT C, GREAT BEND
POOLE MD,BERNARD T, WICHITA
PORTER MD,GARRY L, WICHITA
PORTER MD,MICHAEL G, WICHITA
PORTER MD,ROBERT D, TOPEKA
PORTER MD,SCOTT W, WICHITA
PORTD JR MD,ANTHONY F, SHAWNEE MISSION
PTTTER MD,ROBERT L, KANSAS CITY
PDULDSE MD,ANIL K, LEAVENWORTH
PDULTON MD,THOMAS J, TOPEKA
PDWELL II MD,BENSON M, TOPEKA
PDWELL MD,CARDL W, SHAWNEE MISSION
POWELL MD,KENNETH A, SHAWNEE MISSION
POWELL MD,WILLIAM R, TOPEKA
POWERS MD,G ROBERT, KANSAS CITY
POWERS MD,HARDLD W, SUN CITY,AZ
POWERS MD,K DEAN, WICHITA
PRAEGER MD,MARK A, LAWRENCE
PRASAD MD,BABU, HAYS
PREMSINGH MD,NALINI G, KANSAS CITY
PRENDES MD,CARLOS A, SHAWNEE MISSION
PRENTISS MD,HARDLD, NEWTON
PRESCOTT,JAMES T, WICHITA
PRESKORN MD,SHELDON H, WICHITA
PRESTON MD,DAVID F, KANSAS CITY
PRESTON MD,RALPH R, TOPEKA
PRESTON MD,RICHARD, GREAT BEND
PRETZ MD,JAMES B, KANSAS CITY
PRICE JR MD,LAURANCE W, LAWRENCE
PRICE MD,JAMES GORDON, KANSAS CITY
PRICE MD,PETER G, WINFIELD
PRICE MD,VAUGHAN C, MCPHERSON
PRIETO MD,JORGE N, KANSAS CITY
PROKOP MD,BRADFORD S, TOPEKA
PRONKO MD,MICHAEL J, SHAWNEE MISSION
PROSSER MD,ROBERT L, KANSAS CITY
PROUD MD,G ONEIL, SHAWNEE MISSION
PUGH MD,DAVID M, KANSAS CITY
PULLMAN MD,NORMAN K, CONWAY,AR
PURINTON MD,LEW W, WICHITA
PURKIS,MICHAEL D, KANSAS CITY
PUTNAM,ANTHONY M, KANSAS CITY

Q

QAMAR MD,YUSUF, NEWTON
QUICK MD,WILLIAM W, KANSAS CITY
QUIGLEY MD,JAMES, SHAWNEE MISSION
QUIJAND JR MD,RAMON S, STAFFORD
QUINN MD,CHARLES E, KANSAS CITY
QUINN MD,JOHN MICHAEL, SHAWNEE MISSION
QUINONES MD,ELADIO A, TAMPA,FL

R

RABE MD,MELVIN A, LEAVENWORTH
RAD,SIMA, KANSAS CITY
RADDVANDV MD,RADMILA, WICHITA
RAGHAVAN MD,PARULA P, WICHITA
RAGHAVAN MD,PRAKASH V, WICHITA
RAINBOW-EARHART MD,KATHRYN A, TOPEKA
RAINS,JEFFREY, KANSAS CITY
RAJEWSKI MD,RICHARD L, HAYS
RAJU MD,A S PADMA, TOPEKA
RALSTIN MD,JAMES H, KANSAS CITY
RAMANNA MD,MAGENDRA, WICHITA
RAMIREZ MD,AUGUSTO H, PITTSBURG
RAMIREZ MD,IRENE P, PITTSBURG
RAMSEY MD,BARTLETT W, TOPEKA
RAMSEY,TRACY C, SHAWNEE MISSION
RANDALL MD,GEORGE R, WICHITA
RANDALL MD,GORDON R, TOPEKA
RANDOLPH,MARY K, WICHITA
RANKIN,KRISTIN, SAINT PAUL,MN
RANDELL MD,EDGAR C, TOPEKA
RANSOM MD,JAMES H, TOPEKA
RANSOM,WILLARD B, OTTAWA
RASMUSSEN MD,T J, SHAWNEE MISSION

RASMUSSEN MD,JARDLO L, SALINA
RATE MD,PEGGY S, HUTCHINSON
RATE MD,ROBERT G, HUTCHINSON
RATZLAFF,JAMES D, SHAWNEE MISSION
RAUSA JR MD,FRANCISCO C, WICHITA
RAUSCH MD,MICHAEL A, LINCOLN,NE
RAWCLIFFE JR MD,ROBERT A, WICHITA
RAY MD,DAVID J, CONCORDIA
RAZEK MD,HANA A, WICHITA
RAZEK MD,ZACK A, WICHITA
READ MD,WILLIAM T, COFFEYVILLE
READER MD,G WHITNEY, WICHITA
REALS MD,WILLIAM J, WICHITA
REAZIN MD,WALTER L, WICHITA
RECKLING MD,FREDERICK W, KANSAS CITY
REDDI MD,RAGHUNATH P, WICHITA
REDDY MD,B N, HILL CITY
REDDY MD,P JAGANNADHA, HILL CITY
REDDY MD,SATTI S, DODGE CITY
REDDY MD,SUGUNA N, EL DORADO
REDDY MD,VENUMBACA C, EL DORADO
REDFORD MD,JOHN W B, KANSAS CITY
REDMON DD,MARY L, KANSAS CITY
REEB MD,RONALD JOSEPH, KANSAS CITY
REECE MD,A THOMEN, GARDNER
REECE MD,RICHARD J, SALINA
REED JR MD,WILLIAM D, SHAWNEE MISSION
REED MD,A J, WICHITA
REED MD,D CRAMER, WICHITA
REED MD,DAVID D, WICHITA
REED MD,JAMES S, LAWRENCE
REED MD,RALPH R, WASHINGTON,DC
REED MD,WILLIAM RANDALL, WICHITA
REESE MD,JACK D, LIBERAL
REESE MD,JOHN L, LAWRENCE
REEVES (MC)USNR,CAPT C S, GREAT LAKES,IL
REGAS,STEPHEN L, KANSAS CITY
REGHER,RANDALL S, SHAWNEE MISSION
REGISTER JR MD,G ASHLEY, WICHITA
REICHENBERGER MD,RONALD J, WICHITA
REILE,DANA, SHAWNEE MISSION
REINHARDT-WULF MD,TAISSIA L, GARDEN PLAIN
REINKING MD,VICTOR E, TOPEKA
REISMAN MD,MICHAEL ALAN, WICHITA
REISWIG MD,GARY W, WICHITA
REISWIG MD,JEFFREY S, WICHITA
REIVICH MD,RONALD S, KANSAS CITY,MD
RELIHAN MD,DONALD A, WICHITA
REMPEL MD,JOHN H, WICHITA
RENNER MD,PATRICK A, SHAWNEE MISSION
REPLDGL MD,CHARLES B, GREAT BEND
RETHORST MD,RICHARD D, GIRARD
RETTELE,GARRICK A, KANSAS CITY
REUSSER MD,LAYNE M, ALBUQUERQUE,NM
REYES JR MD,FRANCISCO A, OTTAWA
REYMOND MD,RALPH D, TOPEKA
REYNOLDS MD,TERESA A, WICHITA
REYNOLDS MD,LANCE A, OTTAWA
RHDADS MD, ANNE C, DLTATHE
RHDADS MD,JAMES P, TOPEKA
RHDADS MD,JEFFREY P, TOPEKA
RHODE,MICHAEL G, WICHITA
RHODEN MD,CURTIS H, WICHITA
RHODES MD,IVAN E, WICHITA
RHODES MD,JAMES B, KANSAS CITY
RHODES MD,LDWELL M, WICHITA
RICCI MD,ROBERT LAWLER, TOPEKA
RICE JR MD,FREDERICK A, KANSAS CITY
RICE MD,BERNARD F, SHAWNEE MISSION
RICE MD,RANDALL B, SALT LAKE CITY,UT
RICHARDS MD,DALLAS LEE, HAYS
RICHARDS MD,JOHN F, SALINA
RICHARDS,DAVID A, SHAWNEE MISSION
RICHARDSON II D D,LESTER E, SHAWNEE MISSION
RICHARDSON MD,JAY L, SHAWNEE MISSION
RICHARDSON,KAREN M, DLTATHE
RICHMAN MD,DAVID S, HUTCHINSON
RICHTER MD,DON G, SHAWNEE MISSION
RICK JR MD,GREGORY G, SHAWNEE MISSION
RIDER MD,JAMES W, ATCHISON
RIEG MD,KEVIN P, CHESAPEAKE,VA
RIEGER MD,ERNEST H, WICHITA
RIEKHOF MD,PAUL L, SHAWNEE MISSION
RIFFEL MD,LAWRENCE D, SHAWNEE MISSION
RIGGS MD,KAY R, WICHITA
RILEY MD,RAY B, KANSAS CITY
RINDT MD,PHILLIP L, FREDDRIA
RIRDORAN MD,HUGH D, WICHITA
RIRDORAN MD,TERRANCE, LAWRENCE
RISENHOOVER,EDDIE D, SHAWNEE MISSION
RISING MD,JESSE D, KANSAS CITY,MD
RIVERA D D,DARLA K, WICHITA
RIZZA MD,ROBERT G, HALSTEAD
ROACH MD,NEIL E, WICHITA
RCAN MD,YEAI, WICHITA
ROBERSON,CHERYL L, BLUE SPRINGS,MO
ROBERTS D D,ROGER W, WICHITA
ROBERTS MD,DANIEL K, WICHITA
ROBERTS MD,RICHARD S, LAWRENCE
ROBERTS MD,SHELDON D, GARDEN CITY
ROBERTS MD,WARREN E, TOPEKA
ROBERTSON MD,EDWARD J, SHAWNEE MISSION
ROBERTSON MD,JOSEPH K, WICHITA
ROBINSON MD,DAVID B, TOPEKA
ROBINSON MD,DAVID W, SHAWNEE MISSION
ROBINSON MD,EDGAR L, BELLA VISTA,AR
ROBINSON MD,G DONALD, WICHITA
ROBINSON MD,JOHN D, SHAWNEE MISSION
ROBINSON MD,RALPH G, KANSAS CITY

ROBINSON MD,ROBERT H, WICHITA
ROBINSON MD,MASON W, GARDEN CITY
ROBL MD,DAVID A, WICHITA
ROCK MD,RANDALL W, LAWRENCE
RODERICK MD,JAMES E, SALINA
RODGERS MD,CHRISTOPHER P, HUTCHINSON
RODRIGUEZ MD,PAUL L, GARDEN CITY
RODRIGUEZTUCKER MD,LILIA, WICHITA
ROEDER MD,ROBERT E, TOPEKA
RDMALIS MD,BRIAN E, WICHITA
RDMERIS MD,REX S, SALINA
RDMEREIM,MARK E, WICHITA
RDMERD JR,FRANK, KANSAS CITY
RDMONDD MD,STEVEN A, DLTATHE
RODK MD,LEE E, KANSAS CITY
RODS MD,MAUREEN, WICHITA
RODRABAUGH MD,DONALD C, ABILENE
RODADD,ANTONIO, KANSAS CITY
RODALES MD,J EDGAR, SALINA
ROSE MD,DONALD L, BELLA VISTA,AR
ROSE MD,GRAHAM C, MANHATTAN
ROSE MD,SHELBY D, WICHITA
ROSEBRAUGH MD,CURTIS J, WICHITA
ROSEN MD,CARL H, PRATT
ROSEN MD,DAVID, WICHITA
ROSEN MD,DONALD E, TOPEKA
ROSENBERG MD,ALLAN J, KANSAS CITY
ROSENBERG MD,STANTON L, SHAWNEE MISSION
ROSENBERG MD,THOMAS F, WICHITA
ROSENTHAL MD,RICHARD H, SHAWNEE MISSION
ROSENTHAL MD,STANTON J, KANSAS CITY
ROSDIN MD,ROBERT L, SCOTT CITY
ROSS IV MD,ALBERT M, WICHITA
ROSS MD,DAVID K, ARKANSAS CITY
ROSS MD,DENNIS LEE, WICHITA
ROSS MD,JACK L, TOPEKA
ROTER MD,LARRY, TOPEKA
ROTH MD,ALAN E, KANSAS CITY
ROTHSTEIN MD,TERRY B, PARSONS
ROWLETT MD,JACK G, PADLA
ROY MD,WILLIAM R, TOPEKA
RUBIN MD,HERBERT M, SHAWNEE MISSION
RUBLE JR MD,JAMES L, DVERBROCK
RUBLE MD,REBECCA A, KANSAS CITY
RUCKER,MARK R, WICHITA
RUHLEN MD,JAMES L, DLTATHE
RUHLEN MD,THOMAS F, DLTATHE
RUIZ MD,CARLOS M, GREAT BEND
RUHISEK MD,JOHN D, WICHITA
RUNQUIST MD,BETH, LAWRENCE
RUNNELS MD,JOHN B, PALD ALTO,CA
RUPP MD,JAMES C, SHAWNEE MISSION
RUPP MD,RICHARD J, TOPEKA
RUSSELL MD,PHILIP W, WICHITA
RUTH MD,WILLIAM E, KANSAS CITY
RUTNGAMLUK MD,LUECHA, HAYS
RUZICKA MD,LAWRENCE J, CONCORDIA
RYAN JR MD,RAYMOND J, WICHITA
RYAN MD,JOHN M, MARYSVILLE
RYAN MD,MICHAEL E, SHAWNEE MISSION
RYAN MD,SHERRY L, RAYTOWN,MD
RYMER MD,ROBERT A, SHAWNEE MISSION

S

SABIN JR MD,GEORGE M, WICHITA
SABOR MD,SYED A, WICHITA
SACK MD,JOSEPH M, WICHITA
SADIQ MD,SULEMAN, WICHITA
SADLER MD,PATRICK C, COLUMBIA HEIGHTS,MN
SAEED MD,MOHAMMAD, DERBY
SAFFO MD,KARL S, SHAWNEE MISSION
SAMUEL MD,CHANDY C, WINFIELD
SANCHEZ MD,JOSE J, WICHITA
SANCHEZ MD,RDGLID, TOPEKA
SANDERS MD,J ALAN, LAWRENCE
SANDERS MD,JAMES E, KANSAS CITY
SANDNESS MD,KATHLEEN M, KANSAS CITY
SANTOS MD,FERMIN M, KANSAS CITY
SANTOS MD,JOAQUIN G, WICHITA
SANTOSCOY MD,GILBERT S, WICHITA
SARGENT MD,JOSEPH D, TOPEKA
SATHYANARAYANA MD,SARASWATHI, SHAWNEE MISSION
SATYA-MURTI MD,SATYA, PARSONS
SAVAGE MD,RICHARD, HUTCHINSON
SAWKA MD,LAXMIDAS A, SHAWNEE MISSION
SAXER MD,JOHN J, SHAWNEE MISSION
SAYLOR MD,EDWARD H, TOPEKA
SAYLOR MD,LESLIE L, TOPEKA
SAYLOR MD,MARK, TOPEKA
SAYLOR MD,RANDEL L, HUTCHINSON
SAYLOR MD,STEPHEN, TOPEKA
SCAMMAN MD,W WIKE, TOPEKA
SCANLAN MD,TIMOTHY M, WICHITA
SCANLAN,MARK R, LOMA LINDA,CA
SCANLON JR MD,JAMES H, HADDAM,CT
SCHAEFER MD,JOSEPH PETER, SHAWNEE MISSION
SCHAPER MD,DANIEL C, OLATHE
SCHEEL MD,BRADLEY J, HUTCHINSON
SCHEFFER,RUSSELL E, AUGUSTA,GA
SCHEINBERG MD,KENNETH, WICHITA
SCHELLINGER MD,RICHARD P, EMPORIA
SCHILTZ MD,FRANCES, LA GRANGE,IL

*Probationary members.

SCHLACER MD, ERNEST R, WICHITA
 SCHLAGER MD, JOSEPH G, WICHITA
 SCHLIMMER MD, ROGER B, PITTSBURG
 SCHLICHTER MD, JOHN E, WICHITA
 SCHLICHTER MD, KIMBERLY A, SHAWNEE MISSION
 SCHLOERB MD, PAUL R, KANSAS CITY
 SCHLOESSER CLARK MD, ANNE, WEST WARWICK, RI
 SCHLOESSER MD, HARVEY L, TOPEKA
 SCHLOESSER MD, PATRICIA T, TOPEKA
 SCHLOESSER MD, PETER E, TOPEKA
 SCHLOZMAN MD, DANIEL L, KANSAS CITY, MO
 SCHLUETER MD, JOHN J, WICHITA
 SCHMEIDLER MD, DAVID ALLEN, ARKANSAS CITY
 SCHMIDT MD, HERBERT R, NEWTON
 SCHMIDT MD, MARTY L, FORT SCOTT
 SCHMIDT MD, MICHAEL J, TOPEKA
 SCHMIDT MD, RAMON WARNER, SALINA
 SCHMIDT, DARYN R, KANSAS CITY
 SCHNEIDER MD, SCOTT A, WICHITA
 SCHNEIDER MD, SETH A, WICHITA
 SCHNEIDER, DAVID J, SHAWNEE MISSION
 SCHNELLE MD, JOACHIM, WICHITA
 SCHNIEROW, BRADLEY J, KANSAS CITY
 SCHNOEBELN MD, RENE E, KINSLEY
 SCHNOSE MD, GREGORY D, LAWRENCE
 SCHOEING MD, RICK D, ARKANSAS CITY
 SCHODPF MD, CLIFTON C, WICHITA
 SCHOWENGERDT MD, ANDREW W, MONTEZUMA
 SCHOWENGERDT MD, DANIEL B, WICHITA
 SCHRAM MD, PETER CHARLES, TOPEKA
 SCHREFFER MD, ROSEMARY, SHAWNEE MISSION
 SCHROEDER MD, SYDNEY D, LAWRENCE
 SCHROEDER, SANDRA K, WICHITA
 SCHROFF MD, GREGORY P, KANSAS CITY
 SCHROLL MD, JOHN T, SHAWNEE MISSION
 SCHUETZ MD, PERRY N, GREAT BEND
 SCHUKMAN MD, JAY S, GREAT BEND
 SCHULZ, THOMAS K, WICHITA
 SCHUTZ MD, RALPH A, SHAWNEE MISSION
 SCHWARTING MD, J STEVEN, ABILENE
 SCHWARTZ MD, EUGENE W, DODGE CITY
 SCHWARTZ MD, V DEAN, WICHITA
 SCHWEGLER MD, RAYMOND A, LAWRENCE
 SCHWEGLER MD, RAYMOND A, KANSAS CITY
 SCHWERTFEGER KELS, DEBRA J, KANSAS CITY
 SCHWERTFEGER MD, TY L, WICHITA
 SCHWORM MD, CURTIS P, KANSAS CITY
 SCLAR MD, WILLIAM C, SHAWNEE MISSION
 SCOTT MD, ALEX, JUNCTION CITY
 SCOTT MD, CHESTER E, SALINA
 SCOTT MD, DUANE, BELLEVILLE
 SCOTT MD, WILLIAM H, WICHITA
 SCOTTEN, MITZI S, SHAWNEE MISSION
 SEARIGHT MD, LOWELL R, HIAWATHA
 SEARLE MD, ROBERT E, PITTSBURG
 SEATON MD, ROBERT D, SALINA
 SEBREE MD, STEVEN G, SALINA
 SEEBER, AMY D, EL DORADO
 SEGBRECHT MD, STEPHEN L, LAWRENCE
 SEGLIE MD, F RONALD, PITTSBURG
 SEGUIN MD, JOHN H, KANSAS CITY
 SEHDEV MD, JOAN, TOPEKA
 SEHDEV, KIRAN, KANSAS CITY
 SEHDEV, PAUL S, TOPEKA
 SEIBEL, BRENT E, WICHITA
 SEIDEL MD, DONALD R, ALBUQUERQUE, NM
 SEITZ JR MD, JOSEPH E, ELLSWORTH
 SEITZ, RICHARD F, KANSAS CITY
 SELIGSDN, MICHAEL S, SHAWNEE MISSION
 SELLERS D D, SCOTT, HUTCHINSON
 SELLERS MD, JEFF D, TOPEKA
 SEN SARMA MD, PRONAB K, WICHITA
 SENNE, DIANE L, SHAWNEE MISSION
 SETTLE JR MD, RUSSELL O, SHAWNEE MISSION
 SEVIER MD, SAMUEL M, MUSKOGEE, OK
 SHAAD MD, DOROTHY J, SHAWNEE MISSION
 SHAFAER MD, JAMES J, SALINA
 SHAFAER MD, PRESTON J, WICHITA
 SHAFFER MD, KATHLEEN BRAY, SHAWNEE MISSION
 SHAH MD, ASHOK H, INDEPENDENCE
 SHAH MD, MIAN, LARNED
 SHAH MD, MUKHTAR H, WICHITA
 SHAH MD, NASREEN, LARNED
 SHAH MD, SHARFUDDIN, HALSTEAD
 SHAH, ARJAV A, KANSAS CITY, MO
 SHAPIRO MD, WILLIAM M, WICHITA
 SHARMA MD, ARUN L, PARSONS
 SHARP, CHAD E, WICHITA
 SHAW MD, PAMELA K, KANSAS CITY
 SHAW MD, RICHARD C, WICHITA
 SHAW, JOHN W, WICHITA
 SHEAFER MD, DOUGLAS, TOPEKA
 SHEARS MD, ROBERT N, HUTCHINSON
 SHEEHY MD, PATRICK G, TOPEKA
 SHEERN MD, MARK DOUGLAS, ABILENE
 SHEFFER MD, KEITH D, DLAHE
 SHEFFIELD MD, MICHAEL A, MANHATTAN
 SHELL MD, JOHN R, KANSAS CITY, MO
 SHELLITO MD, JOHN G, WICHITA
 SHELLITO MD, JOHN L, WICHITA
 SHELTON MD, STEPHEN E, TOPEKA
 SHEPPARD MD, ROBERT G, SMITH CENTER
 SHERARD MD, SARAH L, EMPORIA
 SHERIDAN MD, KIM M, SALINA
 SHERIDAN MD, RANDY M, SHAWNEE MISSION

SHERWOOD JR MD, CLARENCE E, TOPEKA
 SHEU MD, W ERIC, TOPEKA
 SHIAD, TSENG-KUD, SHAWNEE MISSION
 SHIELD MD, CHARLES, WICHITA
 SHIELDS JR MD, JAMES M, EL DORADO
 SHIELDS MD, THOMAS M, MANHATTAN
 SHIMSHAK MD, KAREN S, SHAWNEE MISSION
 SHIPPEY MD, DEAN U, WINFIELD
 SHIREMAN MD, PETER K, KANSAS CITY
 SHIVEL MD, DAVID G, GREAT BEND
 SHIVELY MD, ROBERT M, ELLINWOOD
 SHOFFNER MD, RICHARD W, WICHITA
 SHOFSTALL MD, WILLIAM H, SHAWNEE MISSION
 SHORT MD, BRUCE HERSCHEL, SHAWNEE MISSION
 SHRAMER MD, C ERIC, WICHITA
 SHRAMER MD, DOYLE A, WICHITA
 SHRINISE MD, TOM L, ATCHISON
 SHULL D D, MICHAEL W, GARDEN CITY
 SHURTZ MD, GLEN L, WICHITA
 SIEGLE MD, LORA A, COUNCIL GROVE
 SIEMENS MD, RICHARD A, LYONS
 SIFERS MD, TIMOTHY M, SHAWNEE MISSION
 SIFFORD MD, R LAWRENCE, WICHITA
 SILER MD, EUGENE T, HAYS
 SILER, JAMES, WICHITA
 SILLS MD, CHARLES T, NEWTON
 SILLS MD, THOMAS D, KANSAS CITY
 SILVA MD, CATHERINE, LEAVENWORTH
 SILVER MD, BRAD J, SHAWNEE MISSION
 SIMMONS MD, ROBERT EARLE, NEWTON
 SIMMONS, MARK S, SHAWNEE MISSION
 SIMMONS, MICHAEL R, SHAWNEE MISSION
 SIMMONS, SHAWN T, HAYSVILLE
 SIMMS MD, DAVID ALAN, WICHITA
 SIMON MD, STEVEN M, SHAWNEE MISSION
 SIMONE MD, JOSEPH N, SHAWNEE MISSION
 SIMONY-SCLOFSKY MD, M ANN, SHAWNEE MISSION
 SIMPSON MD, ROBERT LIMBAUGH, QUINCY, IL
 SIMPSON MD, TOM C, STERLING
 SIMPSON MD, WILLIAM S, TOPEKA
 SIMS MD, PETER MORRIS, TOPEKA
 SINCLAIR MD, RICHARD H, SHAWNEE MISSION
 SINGER MD, GLEN D, IOLA
 SINGH MD, GIRVAR, ARKANSAS CITY
 SINGH, RAHUL P, KANSAS CITY
 SINN, KRISTINA J, WICHITA
 SINNING MD, GARY, HIAWATHA
 SISK MD, PHILLIP B, TOPEKA
 SIEWEK MD, CHRISTOPHER W, EL DORADO
 SKAER MD, STANLEY ALLEN, EUREKA
 SKIBBA MD, RICHARD M, WICHITA
 SLAGLE, GENELLE J, SHAWNEE MISSION
 SLAUGHTER, JERRY, TOPEKA
 SLOO MD, MILO G, SALINA
 SLUTSKY MD, LAWRENCE JOEL, WICHITA
 SMITH D O, JAMES A M, WICHITA
 SMITH JR MD, FLOYD L, COLBY
 SMITH JR MD, WILLARD J, WICHITA
 SMITH MD, ALVIN L, WICHITA
 SMITH MD, BOYD E, SALINA
 SMITH MD, BRUCE G, ARKANSAS CITY
 SMITH MD, DALE C, ALBERT LEA, MN
 SMITH MD, DAVID E, SALINA
 SMITH MD, DONALD J, SHAWNEE MISSION
 SMITH MD, HARDLO R, SALINA
 SMITH MD, JOHN D, LARNOE
 SMITH MD, JON A, SALINAS, CA
 SMITH MD, LINDALL E, WICHITA
 SMITH MD, MICHAEL L, MADISON HEIGHTS, MI
 SMITH MD, NEWTON C, ARKANSAS CITY
 SMITH MD, PERRY MILTON, GREAT BEND
 SMITH MD, RACHEL, MANHATTAN
 SMITH MD, THOMAS WILLIAM, HUTCHINSON
 SMITH MD, WILLIAM P, SHAWNEE MISSION
 SMITH-KING, MAUREEN M, KANSAS CITY
 SMITH, ANN K IRVING, DLAHE
 SMITH, JACQUELINE, SHAWNEE MISSION
 SMITH, VALDA L, WICHITA
 SNARR MD, JACK W, TOPEKA
 SNIDER MD, BRUCE B, OLATHE
 SNOELL MD, FIRMEN E, SHAWNEE MISSION
 SNOOK MD, ROBERT RUFUS, MCDUTH
 SNOW JR MD, ARTHUR D, SHAWNEE MISSION
 SNOW MD, DONALD L, LEAVENWORTH
 SNOWBARGER MD, MARVIN D, EMPORIA
 SNYDER MD, GREGG M, WICHITA
 SNYDER MD, JULIE, ALBUQUERQUE, NM
 SNYDER MD, RICHARD H, OLATHE
 SNYDER MD, THOMAS E, KANSAS CITY
 SOLLD MD, DAVID G, WICHITA
 SOLLD MD, NATALIE R, WICHITA
 SLOMON MD, HERMAN, WICHITA
 SOLTZ MD, ROBERT A, WICHITA
 SOMERS MD, MARVIN M, WICHITA
 SONGER MD, HERBERT L, ABILENE
 SOSNTHEIMER, DANIEL L, KANSAS CITY
 SOSINSKI MD, RICHARD F, LAWRENCE
 SDOCEK MD, CHARLES D, KANSAS CITY
 SPANGLER MD, HENRY E, TOPEKA
 SPANN MD, RICHARD W, WICHITA
 SPARKS MD, STEPHEN T, WICHITA
 SPEARMAN MD, JESSE L, SAN DIEGO, CA
 SPEARS MD, CHESTER A, EMPORIA
 SPEED MD, JAMES K, WICHITA
 SPEER MD, LELAND, KANSAS CITY
 SPEER MD, LOUIS N, OTTAWA
 SPENCER MD, JOHN HARDLO, FORT SCOTT
 SPENCER MD, MILLARD C, TOPEKA
 SPENCER MD, WAYNE E, TOPEKA

SPERRY MD, ROBERT E, RICHMOND, VA
 SPIEKER MD, JOHN B, KANSAS CITY
 SPIELDOCH, RISA L, KANSAS CITY
 SPITZER MD, JEROME S, HUTCHINSON
 SPRADLIN MD, MICHAEL L, CHERRYVALE
 SPRATT MD, DENNIS P, OTTAWA
 SPRINGER MD, MARK J, WICHITA
 STACEY MD, KIMBALL, INDEPENDENCE
 STADALMAN MD, ROSS EUGENE, HAYS
 STAFFORD MD, ROBERT W, HUTCHINSON
 STAMOS MD, GEORGE E, SHAWNEE MISSION
 STAMPS MD, PHIL, WICHITA
 STANDLEE MD, TIM E, OLATHE
 STANG MD, PATRICK W, GREAT BEND
 STANGA, JAMES, WICHITA
 STANLEY MD, KENNETH E, BIG SPRING, TX
 STANLEY MD, REX C, PAOLA
 STARK MD, JAMES R, WICHITA
 STARKEY MD, DAVID J, EVERETT, WA
 STARKEY MD, JERALD L, RUSSELL
 STASS-ISERN MD, MERRILL, KANSAS CITY
 STECH MD, JOSEPH M, ANDALE
 STECHSCHULTE MD, DANIEL J, KANSAS CITY
 STECKLEY MD, RICHARD ALLEN, WICHITA
 STEEGMANN MD, A THEODORE, CARMEL, IN
 STEELBERG MD, ELSIE, WICHITA
 STEELE MD, CLARENCE H, KANSAS CITY
 STEER MD, PHYLLIS L, KANSAS CITY
 STEEVES MD, JOHN H, EMPORIA
 STEHR MD, CHRISTIAN H, KANSAS CITY
 STEICHEN MD, EDWARD F, LENDRA
 STEIN MD, JOSEPH M, TOPEKA
 STEIN MD, MATTHEW, LAWRENCE
 STEIN MD, PAUL S, WICHITA
 STEINBERGER MD, RICHARD E, WICHITA
 STEINES MD, MICHAEL W, KANSAS CITY
 STEINZIG MD, SHERMAN M, SHAWNEE MISSION
 STEMBRIDGE MD, TRAVIS W, WICHITA
 STEPHANZ JR MD, GERALD B, WICHITA
 STEPHENS D O, G MARCUS, MINNEOLA
 STEPHENS MD, CHARLES, MINNEOLA
 STEPHENSON MD, LUCILLE C, ST FRANCIS
 STEVENS MD, WM. MICHAEL, WICHITA
 STEVENS MD, LEAH J, LEAVENWORTH
 STEVENS MD, MILDRED J, GARNETT
 STEVENS MD, PHILIP L, TONGANDXIE
 STEVENS MD, RONALD, NEWTON
 STEVENSON MD, E KENT, SHAWNEE MISSION
 STEWARD, BRENT E, KANSAS CITY
 STEWART MD, DANIEL L, WICHITA
 STILLIONS, DUANE M, KANSAS CITY
 STITES MD, SANORA R, SHAWNEE MISSION
 STOCK MD, KARL W, TOPEKA
 STOCKTON D O, MICHAEL A, TOPEKA
 STOFFER MD, BERT E, PEDRIA, AZ
 STOFFER MD, ROBERT P, HALSTEAD
 STONE MD, CHESTER W, EMPORIA
 STONE MD, G REX, MANHATTAN
 STONE MD, GRANT C, ATTICA
 STOSKOPF MD, LAWRENCE E, SALINA
 STOUT MD, JAMES M, HUTCHINSON
 STOUT MD, NILES M, LYNDON
 STREET MD, DAVID E, WICHITA
 STREIT MD, JEROME G, WICHITA
 STRICKLAND MD, JOHN T, SHAWNEE MISSION
 STRICKLAND MD, JULIE L, KANSAS CITY
 STRICKLAND MD, M H VAN, WICHITA
 STRIEBINGER MD, CHARLES M, SHAWNEE MISSION
 STRINGFIELD MD, SCOTT L, LYONS
 STRUTZ MD, WILLIAM C, LEAVENWORTH
 STRYKER JR MD, HENRY B, CONCORDIA
 STUBBLEFIELD MD, CHARLES T, KANSAS CITY
 STUBBLEFIELD MD, JENNIFER L, KANSAS CITY
 STUBER MD, JACK L, SHAWNEE MISSION
 STUBLER MD, DANIEL K, HOUSTON, TX
 STUCKEY MD, CHARLES E, SHAWNEE MISSION
 STUCKY MD, DEAN E, MEDICINE LODGE
 STUEWE MD, BRAD R, SALINA
 STUMP MD, HARL G, HAYS
 STURGEON MD, JOHN B, SHAWNEE MISSION
 STURGIS, CHARLES D, WICHITA
 STURICH MD, JORGE M, WINFIELD
 SUERO MD, JESUS T, WICHITA
 SUERO, JAMES A, WICHITA
 SUFI MD, M ASHRAF, TOPEKA
 SUFI MD, QAISER A, TOPEKA
 SUGAR MD, ROBERT L, SHAWNEE MISSION
 SUITER MD, DANIEL JAY, PRATT
 SULLIVAN JR MD, HENRY B, SHAWNEE MISSION
 SULLIVAN LORENSKI, JEANETTE, EASTON
 SULLIVAN MD, CORNELIUS J P, FISHKILL, NY
 SULLIVAN MD, LEONARD L, WICHITA
 SULLIVAN MD, TOM G, SHAWNEE MISSION
 SUMNER MD, JOYCE R, HUTCHINSON
 SUMNER MD, MARION M, HUTCHINSON
 SUMNER MD, RALPH N, FREDONIA
 SUMPTER, MATTHEW T, SHAWNEE MISSION
 SUNDBYE MD, KEVIN R, TOPEKA
 SUTTON MD, ROBERT E, KANSAS CITY, MO
 SVOBODA MD, CHARLES R, CHAPMAN
 SVOBODA MD, LOIS V, WICHITA
 SVOBODA MD, WILLIAM B, WICHITA
 SWAN MD, MAJOR MARTIN, AUBURN, CA
 SWANN MD, CLAIR L, RUSSELL
 SWARTZ MD, MARSHA A, WICHITA
 SWEAT, GREGORY T, KANSAS CITY
 SWEET MD, DONNA E, WICHITA
 SWIFT, TIMOTHY J, KANSAS CITY
 SWIGGER JR MD, GLENN, TOPEKA

*Probationary members.

T

TACKETT MO,ROBERT J, WAMEGO
TADED,RIA E, KANSAS CITY,MO
TAHERNIA MD,CYRUS, TOPEKA
TAKAHASHI MD,TETSURO, TOPEKA
TAKAHASHI,AYAME, WICHITA
TALBERT MD,TIMOTHY C, WICHITA
TAN MD,DONALD C-S, WICHITA
TAN MD,LOURDES R, HAYS
TANANUNKUL MD,URAIWAN, PARSDNS
TANDOC JR MD,VALENTIN T, NEWTON
TANG MD,CHANTRA, PARSONS
TANG MD,SARDHD, PARSONS
TAPPEN MD,DANIEL L, SCOTSDALE,AZ
TARGOWNIK MD,KARL K, TOPEKA
TARNOWER MD,WILLIAM, TOPEKA
TARVER MD,STEPHEN D, WICHITA
TARVIN MD,RANDY J, ONAGA
TATPATI MD,DANIEL A, WICHITA
TATPATI MD,OLGA ADELINA, WICHITA
TAWADROS,HANAN K, WICHITA
TAWIL MD,ELIAS ADIB, PITTSBURG
TAYIEM MD,A K, ATCHISON
TAYLOR MD,BARBARA D, MANHATTAN
TAYLOR MD,CATHY M, CHANUTE
TAYLOR MD,ELMER W, SEDAN
TAYLOR MD,ELWYN J, HUTCHINSDN
TAYLOR MD,STEVEN L, WICHITA
TAYLOR MD,THOMAS F, SHAWNEE MISSION
TAYLOR MD,THOMAS L, SHAWNEE MISSION
TAYLOR,BRADLEY J, LAWRENCE
TEARE MD,MAX E, GARDEN CITY
TEETER MD,SCOTT M, TOPEKA
TEJAND MD,NEDNILD A, HALSTEAD
TEMPERD MD,STEPHEN J, TOPEKA
TEMPLETON MD,ARCH W, KANSAS CITY
TENBY,MICHAEL C, SHAWNEE MISSION
TENNY MD,ROBERT T, SHAWNEE MISSION
TETZLAFF MD,ARCH O A, WEATHERBY LAKE,MO
THAI,VINH Q, SHERMAN DAKS,CA
THAKOR MD,DENNIS S, WICHITA
THALBLUM MD,HARVEY, KANSAS CITY,MO
THELEN MD,J CHRISTINE, WICHITA
THEROU MD,LEDNA F, KANSAS CITY
THODE,JEFF L, KANSAS CITY,MO
THOMAS MD,DARYL L, WICHITA
THOMAS MD,GREGORY MCQUEEN, MCPHERSON
THOMAS MD,JAMES H, KANSAS CITY
THOMAS MD,MARTY H, SHAWNEE MISSION
THOMAS MD,STANLEY M, SHAWNEE MISSION
THOMAS MD,THOMAS V, KANSAS CITY
THOMAS,RYAN M, SHAWNEE MISSION
THOMEN II MD,ROBERT K, CHANUTE
THOMPSON MD,OANIEL M, WICHITA
THOMPSON MD,DANNIE M, KANSAS CITY
THOMPSON MD,MICHAEL F, SHAWNEE MISSION
THOMPSON,CURT, KANSAS CITY
THOMPSON,PH GORDON, WICHITA
THOMS MD,NORMAN W, TOPEKA
THOMSEN MD,GARY, SHAWNEE MISSION
THORNTON III MD,FOXHALL P, OLATHE
THORNTON JR MD,FOXHALL P, CONCOROIA
THORPE MD,FRANCIS A, LAKE ZURICH,IL
THORPE,GARY W, KANSAS CITY
THURSTON MD,DAVID E, TOPEKA
TICKLES MD,DEBRA F, KANSAS CITY
TIEMANN MD,WILLIAM H, MANHATTAN
TIETZE MD,DENNIS D, TOPEKA
TILLER MD,GEORGE R, WICHITA
TILLOTSDN MD,DDN R, ULYSSES
TILSON MD,WAYNE R, LAWRENCE
TILTON MD,FRANK M, GREENVILLE,MA
TILTON MD,FREDERICK E, WICHITA
TINTEROW MD,MAURICE M, WICHITA
TIOJANCO MD,REYNALDO R, KANSAS CITY
TIPPIN JR MD,ERNEST E, ESTES PARK,CO
TIPTDN MD,KYLE M, WICHITA
TISOALE MD,TERRANCE C, HUTCHINSDN
TOALSON MD,WILLIAM B, SHAWNEE MISSION
TOBIAS MD,ROGER R, LYONS
TOBIN MD,KENNETH E, CONCOROIA
TOBY MD,EDWARD B, KANSAS CITY
TOCKER MD,ALFRED M, WICHITA
TOLLER,KEVIN K, KANSAS CITY
TOMASKO MD,MARILYN A, SHAWNEE MISSION
TONN MD,GERHART R, WICHITA
TODHEY MD,JOHN S, WICHITA
TOPLIFF,CONNIE L, LAWRENCE
TDRLINE MD,RONALD L, KANSAS CITY
TOSH MD,FRED E, WICHITA
TDZER MD,RICHARD C, TOPEKA
TRACY MD,TERRY A, WICHITA
TRAN MD, TUDNG M, AUGUSTA
TRAVIS MD,JOHN W, TOPEKA
TREGER MD,NEWMAN V, TOPEKA
TREGO MD,A JASDN, WICHITA
TREMPEY MD,GREGORY A, BALTIMORE,MO
TRETBAR MD,HARVEY A, WICHITA
TRETBAR MD,LAWRENCE L, SHAWNEE MISSION
TREWEEKE MD,MICHAEL W, WICHITA
TRIMBLE SR MD,DAVID P, EMPORIA

TRIDLO MD,PETER A, GARDEN CITY
TROTTIER MD,ROGER COURTNEY, DDDGE CITY
TROUTMAN D O,BETTY, WICHITA
TRUDEAU MD,DAVID L, LAKEVILLE,MN
TRUEWDRTHY MD,RDROBT C, KANSAS CITY
TRUJILLO MD,ANTERO A, WICHITA
TRUONG D O,THANH N, WICHITA
TRYGG MD,KELLY A, WICHITA
TSAI MD,CHIA-HSUN, TOPEKA
TSCHOPP MD,CHARLES F, ANCHORAGE,AK
TTOFI MD,CHRISTOPHER S, NEWINGTON,CT
TUCKER D D,DAVIO A, WICHITA
TUCKER MD,SHERIDAN G, SHAWNEE MISSION
TUCKER MD,VIRGINIA L, KANSAS CITY
TURITTO MD,GIOIA, STATEN ISLAND,NY
TURLEY MD,HAROLO M, WICHITA
TURLEY,BRIAN R, KANSAS CITY
TURNER MD,JOHN W, GARDEN CITY
TURNER MD,ROBERT N, NEWTON
TURNER,LANE E, MANHATTAN
TUTUSKA MD,PETER J, TOPEKA
TWEET MD,FREORICK A, PITTSBURG
TWEITD MD,DAVID H, HUTCHINSON

U

UBELAKER MD,ERNEST J, SOUTH HAVEN
UHLIG MD,PAUL J, WICHITA
UHLIG MD,PAUL N, WICHITA
UHR MD,NATHANIEL, TOPEKA
UNDERWDDO MD,CHARLES C, EMPORIA
UNDERWDDO,JOHN (JOHNSON IV), WICHITA
UNRUH MD,GREGORY K, KANSAS CITY
UNRUH,SUSAN E, AURORA,CO
UTLEY MD,JAMES HARMON, KANSAS CITY,MO
UY MD,WILSON O, COFFEYVILLE

V

VACCA,JOSEPH L, KANSAS CITY
VACHAL MD,EVA, GARDEN CITY
VAL-MEJIAS MD,JESUS E, WICHITA
VALK MD,WILLIAM L, SHAWNEE MISSION
VAN DE VEER MD,SCOTT M, KANSAS CITY
VAN GALLERA MD,ROBERT, WICHITA
VAN GEEM MD,THOMAS A, WICHITA
VAN HOUDEN MD,CHARLES E, CHANUTE
VAN LEEUWEN MD,GERARD J, DES MOINES,IA
VAN SICKLE MD,GREGORY J, TOPEKA
VANDE GARDE MD,LARRY D, TOPEKA
VANDER VELDE MD,STANLEY LERDY, EMPORIA
VANOERVEEN,DEBDRAH K, WICHITA
VANDIVORT MD,OANIEL L, KANSAS CITY
VANNAMEN MD,DONALD O, SHAWNEE MISSION
VANVELDHUIZEN MD,PETER J, SHAWNEE MISSION
VARENHORST MD, MICHAEL P, WICHITA
VARGHESE MD,GEDRGE, KANSAS CITY
VATS MD,TRIBHAWAN S, KANSAS CITY
VAUGHAN MD,D ANN, WICHITA
VEAL, M KATHRYN, WICHITA
VENUTI,SUSAN E, KANSAS CITY
VERMA MD,ASHA, PARSDNS
VERNDN MD,MARY C, LAWRENCE
VESOM MD,PITT, ATCHISON
VIERRA,ANTHONY R, KANSAS CITY
VIERRA,MICHAEL J, KANSAS CITY
VIERTHALER MD,CARL A, DODGE CITY
VIERTHALER MD,LYLE D, WICHITA
VIERTHALER MD,STEPHEN L, LAWRENCE
VILLARANTE MD,FE T, HAYS
VIN ZANT MD,LARRY E, WICHITA
VINE MD,DONALD LEE, WICHITA
VINZANT MD,MARK N, DERBY
VINZANT MD,WHITNEY L, WICHITA
VISHTEH,ARMIN, KANSAS CITY,MO
VOODNICK MD,DAVIO S, SHAWNEE MISSION
VOGEL MD,STANLEY J, TOPEKA
VOGT MD,VERNDN W, NEWTON
VOLKMAN II MD,HARLEY W, MANHATTAN
VODREES MD,CARRDL D, LEAVENWORTH
VODREES MD,GORDDN S, LEAVENWORTH
VORAN MD,DAVID A, SHAWNEE MISSION
VORHEES MD,VICTOR J, YATES CENTER
VOSSLER,CHARLES, KANSAS CITY
VOTAPKA MD,WILLIAM L, STOCKTON
VOTH MD,ERIC A, TOPEKA
VU,ANN L, KANSAS CITY
VU,TRIEB B, KANSAS CITY

W

WACHS MD,THEODORE J, GARDEN CITY

WADE MD,EDWARD J, WICHITA
WADE MD,THEDDRE E, LIBERAL
WADUD MD,ABDUL, WICHITA
WAGENBLAST MD,HDWARD R, SALINA
WAHBEH,ANTHONY, KANSAS CITY
WAKEFIELD MD,KENNETH M, WICHITA
WALD MD,JEFFREY A, SHAWNEE MISSION
WALDRFF JR MD,MELVIN H, GREENSBURG
WALIA MD,JAG S, TOPEKA
WALKER D D,MARSHALL D, WICHITA
WALKER MD,ANDY E, BELLEVILLE
WALKER MD,JACK D, SHAWNEE MISSION
WALKER MD,NELLIE G, LEE'S SUMMIT,MO
WALKER MD,WILLIAM H, ESKRIDGE
WALKER MD,WILLIAM K, SEDAN
WALL MD,DAVID M, WICHITA
WALL MD,TERRY J, TOPEKA
WALLACE D D,RICHARD B, WICHITA
WALLACE JR MD,WAYNE O, ATCHISON
WALLACE MD,BRETT E, TOPEKA
WALLACE MD,LEO F, TOPEKA
WALLING MD,ADRIAN E, WICHITA
WALLING MD,ANNE O, WICHITA
WALLS MD,WILLIAM J, TOPEKA
WALSH D O,LESLIE L, WICHITA
WALSH MD,THOMAS E, ONAGA
WALTERS MD,BYRDN W, SUN CITY,AZ
WALTON,PATRICIA L, KANSAS CITY
WALTON,TERRI D, KANSAS CITY
WALZ MD,ROYCE C, TOPEKA
WAMSLEY MD,CRAIG A, LAKIN
WANG MD,SIDNEY W, SHAWNEE MISSION
WANGER,MICHAEL P, KANSAS CITY
WANLESS MD,KIRK M, TOPEKA
WARD MD,CYNTHIA L, WICHITA
WARD MD,HOWARD N, TOPEKA
WARO MD,JAMES A, BELLEVILLE
WARO MD,LARRY G, WICHITA
WARE MD,LUCILE M, TOPEKA
WARNER MD,RICHARD B, OLATHE
WARNDCK MD,JULIA K, KANSAS CITY
WARREN JR MD,JOHN W, WICHITA
WARREN MD,LINDA D, HANDOVER
WARREN MD,LYDD P, WICHITA
WARREN MD,ROGER D, HANDOVER
WARREN MD,WIRT A, WICHITA
WARREN,RONDA L, KANSAS CITY
WARRICK MD,DAVID ALAN, TOPEKA
WASHBURN MD,MICHAEL E, LEAVENWORTH
WASHINGTON,CHARMETRA R, KANSAS CITY
WASINGER,LORI O, SHAWNEE MISSION
WATERS MD,CLARENCE N, SALINA
WATKINIS,DEAN D, KANSAS CITY
WATKINS MD,STEVEN C, TOPEKA
WATSDN MD,RICHARD L, ANDOVER
WATTS MD,HARRY E, HAYS
WAUGH MD,CHARLES W, TOPEKA
WAXMAN MD,DAVID, SHAWNEE MISSION
WAXMAN MD,STEVE, KANSAS CITY
WEATHERSTONE MD,KATHLEEN B, KANSAS CITY
WEAVER MD,JACK D, WICHITA
WEAVER MD,WALTER D, TOPEKA
WEBB MD,DAVID E, WICHITA
WEBB MD,JAMES R, SHAWNEE MISSION
WEBER II MD,RALPH H, TOPEKA
WEBER JR MD,HUGO P, WICHITA
WEBER MD,DARRELL J, TOPEKA
WEBER MD,ROBERT W, SALINA
WEBER MD,RDY R, HALSTEAD
WEBER MD,RUTH M, YATES CENTER
WEBER MD,WALLACE N, HAYS
WEBSTER MD,BOBBY W, WICHITA
WEDDLE MD,DOUGLAS P, FORT SCOTT
WEDEL MD,ALAN K, SALINA
WEDEL MD,KENNETH D, MINNEAPOLIS
WEDEL MD,KERMIT G, MINNEAPOLIS
WEED MD,JOHN C, KANSAS CITY
WEEKS MD,STACY S, TOPEKA
WEIDENSAUL MD,D N, HUTCHINSDN
WEIGAND MD,JOEL T, WELLINGTON
WEIGEL MD,JOHN W, KANSAS CITY
WEIGHARD MD,MICHAEL, SHAWNEE MISSION
WEILERT MD,STEVEN V, FORT SCOTT
WEINER MD,GARY B, SHAWNEE MISSION
WEINGART MD,JAMES H, SHAWNEE MISSION
WEIPPERT MD,EDWARD J, WICHITA
WEISHAAR MD,PAUL D, MIAMI,FL
WELCH MD,JAMES R, PARSONS
WELCH MD,LAUREN A, GARDEN CITY
WELCH MD,LAUREN K, WICHITA
WELCH MD,MAURA S, GARDEN CITY
WELCH MD,WADE B, CHICAGO,IL
WELL MD,MICHAEL A, LAWRENCE
WELLS MD,BRUCE W, WINFIELD
WELSH MD,NANCY JANE, TOPEKA
WELTNER MD,ROGER P, BELOIT
WENGER MD,GREGG D, SABBETHA
WENINGER MD,JOHN H, WICHITA
WERNER MD,JAMES P, TOPEKA
WERNER MD,WILLARD F, ATWOOD
WERTH MD,DARRELL D, HAYS
WERTZBERGER MD,JOHN, LAWRENCE
WESBROOK MD,C WILSON, WICHITA
WESCE MD,W CLARKE, SPICER,MN
WESLEY MD,MICHAEL R, HUTCHINSON
WEST MD,WILLIAM T, WICHITA
WESTFALL,JOHN M, WICHITA
WETZEL MD,JAMES L, OLATHE
WETZEL MD,MARK, MANHATTAN

*Probationary members.

WHEEL MD,DWIGHT E, NEWTON
 WHEEL MD,NICKY RAY, WICHITA
 WHEELER MD,PINCKNEY R, WICHITA
 WHISAKER MD,JAMES A, WICHITA
 WHISAKER MD,MARK A, SHAWNEE MISSION
 WHITE D D,JOHN P, PITTSBURG
 WHITE II MD,BENJAMIN E, EL DORADO
 WHITE MD,CHARLES L, QUINCY,WA
 WHITE MD,CHARLES M, WICHITA
 WHITE MD,DONALD C, COFFEYVILLE
 WHITE MD,FAGAN N, RUSSELL
 WHITE MD,NELSON P H, BURLINGTON
 WHITE MD,R BURNLEY, WINFIELD
 WHITEHEAD MD,RICHARD E, SHAWNEE MISSION
 WHITESIDE MD,WILLIAM H, WICHITA
 WHITFIELD MD,STEVEN S, SHAWNEE MISSION
 WHITLEY MD,DOUGLAS M, SHAWNEE MISSION
 WIBLE MD,KENNETH L, KANSAS CITY
 WICINA,GENDON M, SHAWNEE MISSION
 WIEBE,ERIC, WICHITA
 WIEGHARD MD,CHARLES M, SHAWNEE MISSION
 WIENS MD,J WENDELL, NEWTON
 WIENS MD,JONATHAN G, SHAWNEE MISSION
 WIENS MD,LYNN A, KANSAS CITY,MO
 WIGGINTON O O,GERALD O, SHAWNEE MISSION
 WIGGLESWORTH MD,ANNE, MANHATTAN
 WILCOX JR MD,HOWARD L, HAYS
 WILCOX,RONALD D, KANSAS CITY
 WILDER MD,LOWELL W, WICHITA
 WILDS MD,CHARLES E, BELLA VISTA,AR
 WILES MD,DENNIS D, WICHITA
 WILEY MD,CLARENCE L, HUTCHINSON
 WILEY MD,JOHN H, SHAWNEE MISSION
 WILEY MD,THOMAS M, TOPEKA
 WILFONG,DAVID, KANSAS CITY
 WILKINSON MD,LARRY K, WICHITA
 WILLCOX,JAMES A, SALT LAKE CITY,UT
 WILLIAMS MD,CHARLES L, WICHITA
 WILLIAMS MD,EVAN R, MESA,AZ
 WILLIAMS MD,HOMER J, LAGUNA NIGUEL,CA
 WILLIAMS MD,MICHAEL K, NEWTON
 WILLIAMS MD,RONALD P, SAN ANTONIO,TX
 WILLIAMS MD,THOMAS A, SHAWNEE MISSION
 WILLIAMS,GARY G, SHAWNEE MISSION
 WILLIAMSON MD,STEPHEN K, KANSAS CITY
 WILSON MD,DAVID B, KANSAS CITY
 WILSON MD,J WELLS, WICHITA
 WILSON MD,JAMES W, COFFEYVILLE
 WILSON MD,LORI J, SHAWNEE MISSION
 WILSON MD,ROBERT A, DODGE CITY
 WILSON MD,ROBERT B, SHAWNEE MISSION
 WILSON MD,ROBERT L, WICHITA
 WILSON MD,SLOAN J, SHAWNEE MISSION
 WILSON,MICHAEL A, WICHITA

WIN MD,AYE M, DODGE CITY
 WINBLAD MD,J KENT, WINFIELD
 WINBLAD MD,JAMES N, WINFIELD
 WINBLAD MD,JOHN M, WINFIELD
 WINDHOLZ MD,ARTHUR F, WICHITA
 WINN MD,TERRIA L, WICHITA
 WISDOM MD,JAY K, SUN CITY,AZ
 WISE MD,JOSEPH E, KANSAS CITY
 WISNER JR MD,HARRY J, WICHITA
 WITTMAN MD,A T, DE SOTO
 WITTMANN MD,ALBERT F, WICHITA
 WOHLER MD,JOHN P, SAN ANTONIO,TX
 WOLF MD,KARL T, KANSAS CITY
 WOLF MD,PATRICK G, WICHITA
 WOLF MD,STEPHEN B, COLUMBUS
 WOLF,CHRISTINE, SHAWNEE MISSION
 WOLFE MD,BRIAN D, IOLA
 WOLFE MD,FREDERICK, WICHITA
 WOLFE,ANNE-MARIEKE, KANSAS CITY
 WOLFF MD,FREDERICK P, KANSAS CITY,MO
 WOLFRAM,DONALD P, WICHITA
 WOLKOFF MD,CDR A STARK, HONOLULU,HI
 WOLLMANN MD,MARTIN, LAWRENCE
 WOOD JR,RD,BERT A, SHAWNEE MISSION
 WOOD MD,EDWARD R, TOPEKA
 WOOD MD,FRED M, SHAWNEE MISSION
 WOOD MD,GARY B, WICHITA
 WOOD MD,GARY L, ARKANSAS CITY
 WOOD MD,ROBERT D, WICHITA
 WOODALL MD,DENNIS C, SALINA
 WOODHOUSE MD,CHARLES L, WICHITA
 WOODRING MD,CATHY S, WICHITA
 WOODS MD,DENNIS D, HUTCHINSON
 WOODS MD,GREGORY A, HAYS
 WOODS MD,S DWIGHT, OLATHE
 WDRTMAN MD,JACK A, HUTCHINSON
 WRAY JR MD,REGINALD P, WICHITA
 WRAY MD,ALEXANDER J, WICHITA
 WRIGHT MD,KENDALL M, EMPORIA
 WRIGHT MD,STANLEY E, WICHITA
 WU MD,JIN-TZE, WICHITA
 WURSTER MD,G. RICHARD, SHAWNEE MISSION
 WYATT-HARRIS MD,PATRICIA G, WICHITA

YAGHMUDR MD,TALAA E, PITTSBURG
 YANG,ALEXANDER O, KANSAS CITY
 YAUSSI MD,MARGARET H, SHAWNEE MISSION

YEE,AUDREY S, WICHITA
 YEH MD,RD,BERT M, TOPEKA
 YEDMANS MD,RD,NALD N, SHAWNEE MISSION
 YDACHIM MD,ROBERT W, ARKANSAS CITY
 YDAKUM PYLE,MARGARET, KANSAS CITY
 YODER MD,EMERSON D, DENTON
 YODER MD,VERNON E, HESSTON
 YOESEL,MICHAEL, OLATHE
 YOHE MD,RUTH M, SHAWNEE MISSION
 YOON MD,CHANG SUP, WICHITA
 YORKE JR MD,CRAIG H, TOPEKA
 YOST JR MD,JOHN G, KANSAS CITY,MO
 YOUN MD,HWAN, GREAT BEND
 YOUNG MD,CHARLES H, ATCHISON
 YOUNG MD,DOUGLAS L, WICHITA
 YOUNG MD,JOHN W, SHAWNEE MISSION
 YOUNG MD,PAUL E, TOPEKA
 YOUNG MD,ROBERT C, WICHITA
 YOUNG MD,THEODORE E, TOPEKA
 YOUNGBERG MD,DEAN I, WICHITA
 YOUNGLOVE MD,HAL, SHAWNEE MISSION
 YOUNGMAN MD,DARRELL J, WICHITA
 YOYALL,KELLY E, KANSAS CITY
 YULICH MD,JOHN O, SABETHA
 YUT JR MD,JOSEPH P, SHAWNEE MISSION

Z

ZABEL MD,KENNETH P, PITTSBURG
 ZACHARIAS MD,DAVID LLOYD, TOPEKA
 ZACK MD,ASHLEY S, SHAWNEE MISSION
 ZAINALI MD,ASSADOLLAH, LIBERAL
 ZAMIEROWSKI MD,DAVID S, SHAWNEE MISSION
 ZARNOW MD,HILARY, WICHITA
 ZARR MD,JAMES S, KANSAS CITY,MO
 ZATZKIN MD,JAY B, WICHITA
 ZAUCHE MD,JAMES T, GARDEN CITY
 ZAYLOR D O,CHARLES L, NEWTON
 ZEILER MD,STEVEN B, OLATHE
 ZELLER MD,MYRON J, GARDEN CITY
 ZEPICK MD,LYLE F, WICHITA
 ZERBE MD,KATHRYN, TOPEKA
 ZIEGLER MD,MARK L, WICHITA
 ZIELKE MD,STEVEN L, WICHITA
 ZIMMERMAN MD,BRUCE E, OLATHE
 ZIMMERMAN MD,KENNETH D, WICHITA
 ZIMMERMAN MD,WILLIAM H, TOPEKA
 ZINN MD,THOMAS W, KANSAS CITY
 ZONGKER MD,PHILIP E, WICHITA
 ZUERCHER,PAUL S, WICHITA
 ZWIACHER MD,KAYE, WICHITA

Y

*Probationary members.

Physician Distribution by Cities

EXPLANATION OF CODES USED IN THIS SECTION

Line 1:	Doe, John R.,	1234 Oak St.,	67052		
	(Name)	(Street Address)	(Zip Code)		
Line 2:	(654-2222)		123456789		
	(Telephone Number)		(I.D. Number)		
Line 3:	33	M	1902	58	FP
	(Year of Birth)	(Sex)	(Medical School)	(Year of Licensure)	(Specialty)

Telephone area code follows city name. * Probationary Members

ABILENE — 913

(Dickinson County Medical Society)

BERKLEY MD,DDN H, 1111 N BRADY, 67410
263-4131 1902610061
35 M 1902 62 FP

BIGGS MD,J DENNIS, 1405 N CEDAR, 67410
263-719D 1902740D97
48 M 1902 74 FP

CHAFFEE MD,DEAN C, RR 1, 67410
1902440298
11 M 19D2 44 OD

COLEMAN MD,GARY, 1405 N CEDAR, 67410
263-7190 1902720223
46 M 1902 73 FP

MOHLER MD,JACK M, 420 NE TENTH, 67410
263-1419 1902610592
32 M 1902 62 PM

NARCISO MD,VICENTE D, 515 NE 10TH ST, 67410
263-2253 74810680052
45 M 74810 76 GS

RORABAUGH MD,DONALD C, PROFESSIONAL BLDG 1111 BRADY, 67410
263-4131 1902580782
33 M 1902 59 FP

SCHWARTING MD,J STEVEN, 1405 N CEDAR, 67410
263-7190 3401720307
46 M 34D1 73 FP

SHEERN MD,MARK DOUGLAS, 1111 N BRADY, 67410
263-4131 1902761221
51 M 19D2 77 FP

SONGER MD,HERBERT L, 1007 SPRUCEWAY, 67410
1902380546
12 M 1902 38 OD

ALTAMONT — 316

(Labette County Medical Society)

JACKSON MD,VICTOR L, BOX 467, 67330
2105500257
20 M 2105 54 OD

AMES — 913

(Cloud County Medical Society)

FREEBORN JR MD,WARREN S, RR 2 BDX 59, 66931
1720510312
26 M 1720 60 OD

ANDALE — 316

(Sedgwick County Medical Society)

STECH MD,JOSEPH M, PO BOX 38, 67001
796-0601 3D06560660
27 M 3006 57 FP

ANDOVER — 316

(Sedgwick County Medical Society)

BEECH MD,RANDALL R, 524 N ANDDVER RD PO BOX 496, 67002
733-1331 19028D1509
54 M 19D2 81 GS

LEMONS MD,STEPHEN F, 524 N ANDOVER RD PO BOX 496, 67002
733-1331 1902821020
54 M 1902 83 FP

WATSON MD,RICHARD L, 524 N ANDOVER RD, 67002
733-1331 1902851891
59 M 1902 FP

ANTHONY — 316

(Ninnescah Medical Society)

ANTRIM MD,PHILIP JENIFER, BOX 84 RT 1, 67003
1902420033
15 M 1902 42 OD

ARKANSAS CITY — 316

(Cowley County Medical Society)

ALVAREZ MD,NORBERTO, 515 N SUMMIT, 67005
442-4850
29 M 27501 73 FP

AUCAR MD,ALFREDO, BOX 1105, 67005
442-1710 27501531303
23 M 275D1 70 DTD

CAMPBELL MD,GARLAND L, 1711 N 4TH ST #302, 670D5
19D2400113
13 M 1902 40 OD

CRANE WHITE MO, REBECCA, 510 W RADIO LANE, 67005
442-2100 1902850348
59 F 1902 88 FP

HILL MD, JAMES E, 1019 N SECOND, 67005
1902340277
09 M 1902 34 00

MARVEL MO, JAMES EBBERT, 2545 N GREENWAY, 67005
441-0222 3901680573
43 M 3901 72 ORS

MORTON MD, ROBERT A, AC OFFICE BLDG #300, 67DD5
442-0370 1902782172
51 M 1902 80 IM

OLO MO, JERRY L, 510 W RADIO LN, 67005
442-2100 1902741701
49 M 1902 75 FP

PEREIRA MD, WILLY G, PO BOX 718, 67005
442-8540 73701670091
39 M 73701 73 IM

ROSS MO, OAVIO K, PO BOX 1148 510 W RADIO LN, 67005
442-2100 1902740968
48 M 1902 75 FP

SCHMEIDLER MD, DAVID ALLEN, 510 W RADIO LN PO BDX 1148,
67005
442-2100 1902791589
54 M 1902 82 FP

SCHOELING MO, RICK O, 510 W RADIO LANE, 67005
442-2100 1902861498
59 M 1902 89 FP

SINGH MO, GIRVAR, 2508 EOGEMONT DR, 67005
442-4300 49555640021
40 M 49555 78 OPH

SMITH MD, BRUCE G, 210 S 2ND, 67005
1902441421
20 M 1902 44 00

SMITH MD, NEWTON C, PO BDX 1148, 67005
442-2100 3901450594
21 M 3901 51 FP

WOOD MD, GARY L, 401 N SUMMIT, 67005
442-0103 64936810053
52 M 64936 83 R

YOACHIM MD, ROBERT W, 510 W RADIO LN PO BDX 1148, 67005
442-2100 3005781417
52 M 3005 80 FP

ATCHISON — 913 (Atchison County Medical Society)

8OSSE MD, FRANK K, 1301 RIVERVIEW DR, 66002
2802330106
09 M 2802 36 00

BURKE MO, JOSEPH V, 14DD N SECOND, 66002
367-5496 3DD666D125
35 M 3006 71 GS

EPLER MD, JOHN R, 1225 N SECOND, 66D02
367-0880 1902780595
53 M 1902 82 FP

FAST MO, ROBERT E, 1225 N 2ND, 66002
367-D362 1902740283
48 M 1902 75 OBG

FAST MO, W SPENCER, 13D1 N SECOND, 66DD2
367-7417 3006390268
11 M 3006 40 FP

GROWNEY MD, DANIEL J, 1301 M 3RD ST, 66002
367-3400
59 M 30D6 87 GS

HART MO, LAWRENCE E, 1412 N 2ND, 66D02
367-5D54 19D2640351
32 M 1902 65 FP

JONES MD, MICHAEL P, 1225 N 2ND, 66002
367-0880 1902830991
55 M 1902 85 FP

LYNE MO, ALAN W, 1225 N 2ND, 66002
367-0880 1902841527
57 M 1902 88 FP

MORRISON MO, IRA R, 825 N TENTH, 66002
161136D696
07 M 1611 38 00

RIOER MO, JAMES W, 1225 N 2ND, 66002
367-0861 2803730744
47 M 2803 76 FP

SHRIWISE MD, TOM L, 1301 N 2ND, 66D02
367-3646 1902810711
54 M 1902 ORS

TAYIEM MO, A K, 1225 N SECOND, 66002
367-1114 33002680012
43 M 33002 72 GS

VESOM MD, PITT, 1301 N 2ND, 66002
367-3100 89102740085
49 M 89104 83 CD

WALLACE JR MD, WAYNE O, 1301 N 3RD, 66002
367-7300 2803650732
36 M 2803 67 FP

YOUNG MO, CHARLES H, 1301 N 3RD, 66002
367-4053 1902530980
23 M 1902 53 FP

ATTICA — 316 (Ninnescah Medical Society)

STONE MO, GRANT C, 500 N HARPER, 67009
254-7219 5605350480
08 M 5605 69 FP

ATWOOD — 913 (Northwest Kansas Medical Society)

WERNER MD, WILLARD F, PO BOX 5, 67730
626-3241 1902520755
24 M 1902 52 FP

AUGUSTA — 316 (Butler-Greenwood County Medical Society)

ANDERSON MD, OALE W, 120 W JOSEPHINE, 67010
775-5432 1902550018
30 M 1902 55 FP

BARBER MO, JAMES L, 120 W JOSEPHINE, 67010
775-5432 1902570035
31 M 1902 57 FP

TRAN MO, TUONG M, 120 W JOSEPHINE, 67010
775-5432 94101720131
39 M 94101 77 FP

BASEHOR — 913 (Wyandotte County Medical Society)

BURGER MD, WILLIAM E, RT 1, 66007
3006510069
21 M 3006 51 OD

BAXTER SPRINGS — 316
(Crawford-Cherokee County Medical Society)

ALQUIST MD, VERYL D, 21ST & FAIRVIEW, 66713
1902420017
17 M 1902 42 00

BELLEVILLE — 913
(Republic County Medical Society)

DOUBEK MD, HERBERT D, PO BOX 250, 66935
527-2237 1902560323
28 M 1902 56 FP

HOLT MD, ROBERT E, 2316 G, 66935
527-2237 702760518
59 M 1902 77 FP

SCOTT MD, DUANE, 1206 18TH, 66935
527-2217
34 M 1902 61 FP

WALKER MD, ANDY E, 2217 18TH, 66935
527-2217 1902871795
61 M 1902 88 FP

WARD MD, JAMES A, RR 2 BOX 106, 66935
1902581002
34 M 1902 59 DO

BELOIT — 913
(Mitchell County Medical Society)

CONCANNON MD, CRAIG A, 310 W 8TH, 67420
738-2246 1902840415
58 M 1902 IM

DOBRTATZ MD, ROBERT A, 700 N PINE, 67420
1902520224
24 M 1902 52 DO

DRAKE MD, DOUGLAS J, 112 W MAIN PD BOX 605, 67420
738-2246 1902710317
43 M 1902 72 FP

FUGATE MD, CARL L, 310 W 8TH, 67420
738-2246 1902840601
57 M 1902 FP

KLEND JR MD, MARTIN B, BELOIT MED CTR 310 W 8TH, 67420
738-2246 1643630351
38 M 1643 66 GS

WELTNER MD, ROGER P, PO BOX 571, 67420
1902441588
18 M 1902 44 00

BLUE RAPIDS — 913
(Northeast Kansas Medical Society)

BUCK JR MD, WILLIAM D, 607 LINCOLN, 66411
226-7202
59 M 1902 89 FP

LAWLESS MD, HAROLD L, 607 LINCOLN, 66411
702540381
29 M 702 58 00

BONNER SPRINGS — 913
(Wyandotte County Medical Society)

MAY MD, KENNETH L, 525 MACGRANTWOOD DR, 66012
1902510482
20 M 1902 41 00

BUCKLIN — 316
(Iroquois County Medical Society)

LUNA MD, ANTHONY D, 203 N MAIN, 67834
826-3266 1902821071
54 M 1902 83 FP

BUFFALO — 316
(Southeast Kansas Medical Society)

BEAL MD, RAYMOND J, RR #1 BOX 21, 66717
1902380031
12 M 1902 38 00

BURLINGTON — 316
(Flint Hills Medical Society)

WHITE MD, NELSON P H, 824 N 4TH ST, 66839
364-5395 3901630835
34 M 3901 90 FP

CANEY — 316
(Southeast Kansas Medical Society)

COLE MD, RICHARD F, PO BOX 325, 67333
879-2128 515710078
41 M 515 FP

MDDRE MD, ROBERT F, 601 S HIGH, 67333
879-2135 1902560765
28 M 1902 56 FP

CARBONDALE — 913
(Shawnee County Medical Society)

HORNBAKER MD, STANLEY D, 211 E MAIN, 66414
564-7111 1902820805
56 M 1902 IM

CHANUTE — 316
(Southeast Kansas Medical Society)

ABBUEHL MD, DON R, 932 WINDSOR, 66720
1902440018
18 M 1902 44 00

ASHLEY MD, SAMUEL G, 505 S PLUMMER, 66720
1902430021
16 M 1902 43 00

BURKMAN MD, REUBEN J, 1501 W 7TH, 66720
431-9310 1902540101
28 M 1902 54 FP

GEHRT MD, EARL B, 505 S PLUMMER, 66720
431-250D 1902620261
32 M 1902 63 FP

KIHM MD, ALBERT A, 505 S PLUMMER, 66720
431-25DD 1902550646
27 M 1902 55 FP

MABEN MD, PAMELA S, 505 S PLUMMER, 66720
431-250D 1902791210
54 F 1902 80 IM

MC LAND MD, GRETA S, 505 S PLUMMER, 66720
431-2500 1902791295
54 F 1902 81 PD

PARHAM MD, VEROON W, 505 S PLUMMER, 66720
431-2500 1902731411
47 M 1902 75 FP

TAYLOR MD, CATHY M, 1409 W 7TH, 66720
431-0340 1902831289
57 F 1902 88 OBG

THOMEN II MD, ROBERT K, 505 S PLUMMER, 66720
431-2500 1902841802
59 M 1902 86 FP

VAN HOUDEN MD, CHARLES E, 505 S PLUMMER, 66720
431-2500 1902761434
52 M 1902 77 GS

CHAPMAN — 913 (Dickinson County Medical Society)

HAMEL MD, GREGORY L, 413 N MARSHALL, 67431
922-6400 1902820678
56 M 1902 85 FP

SVOBODA MD, CHARLES R, 225 W 9TH PO BOX 218, 67431
1902460663
18 M 1902 46 00

CHETOPA — 316 (Labette County Medical Society)

PEFFLY MD, ELMER D, 327 MAPLE BOX 266, 67336
236-7188 3901530601
22 M 3901 56 FP

CIMARRON — 316 (Ford County Medical Society)

HOSTETLER MD, ROBERT W, 111 S MAIN, 67835
855-7717
55 M 1902 88 FP

CLAY CENTER — 913 (Clay County Medical Society)

BROWNING MD, JIMMIE L, PO BOX 520, 67432
632-2181 1902780285
50 M 1902 79 FP

BUTT MD, MUHAMMED, 2201 7TH, 67432
632-2191 70401690156
46 M 70401 GS

OALUM MD, PETER JOSEPH, PO BOX 520, 67432
632-2181 2803760163
45 M 2803 77 FP

ERICKSON MD, KENT E, PO BOX 520, 67432
632-2181
56 M 1902 FP

HATESOHL MD, STANLEY M, PO BOX 520, 67432
632-2181 1902840750
57 M 1902 87 FP

PENNER MD, TIMOTHY M, PO BOX 520, 67432
632-2181 1902861331
59 M 1902 FP

CLYDE — 913 (Cloud County Medical Society)

COULTER O O, THAYNE A, 306 N HIGH, 66938
2878370034
12 M 2878 37 00

COFFEYVILLE — 316 (Southeast Kansas Medical Society)

BLOCK MD, JEROME E, PO BOX 464, 67337
251-2400 3305640033
38 M 3305 IM

CAMPBELL MD, WILLIAM H, 1411 W 4TH STE D, 67337
251-3235 1902650098
39 M 1902 66 OPH

CHILLAL MD, PANDURANG P, 801 W 8TH ST, 67337
251-7505
49 M 49535 87 IM

DICKINSON MD, CHARLES R, 608 SPRUCE, 67337
1606450300
20 M 1606 47 00

OIXON MD, RAYMOND W, 808 WILLOW #1, 67337
251-1090 4706711312
46 M 4706 77 GS

HAN MD, CHAN S, 908 SIGGINS, 67337
251-1560 58306610048
35 M 58306 74 PD

HO MD, SAMUEL, 1501 W 4TH ST, 67337
251-2400 1902850771
58 M 1902 88 IM

HOWERTER JR MD, BERNARD E, PO BOX 659, 67337
251-4790 1803680490
43 M 1803 73 U

MILLER D O, STEPHEN A, PO BOX 489, 67337
251-0777 2878760509
47 M 2878 87 OBG

READ MD, WILLIAM T, 411 W 9TH, 67337
251-1120 2802400678
16 M 2802 46 FP

UY MD, WILSON O, COFFEYVILLE MEM HOSP 101 TYLER, 67337
251-1200 74801670192
42 M 74801 73 PATH

WHITE MD, DONALD C, PO BOX 1449, 67337
251-1200 3515650694
35 M 3515 72 R

WILSON MD, JAMES W, 1802 W 4TH PO BOX 469, 67337
251-5210 3901580790
26 M 3901 GP

COLBY — 913 (Northwest Kansas Medical Society)

KOLSTE MD, REX J, 310 E COLLEGE, 67701
462-7565 3005790742
53 M 3005 83 FP

SMITH JR MD, FLOYD L, 880 SUNSET, 67701
1902441430
20 M 1902 44 00

COLDWATER — 316 (Iroquois County Medical Society)

GOERING MD, DONALD D, BOX 748, 67029
582-2136 1902560421
31 M 1902 56 FP

COLUMBUS — 316
(Crawford-Cherokee County Medical Society)

WOLF MO,STEPHEN B, 301 N KANSAS, 66725
 429-3636 19028621920
 51 M 1902 PO

CONCORDIA — 913
(Cloud County Medical Society)

BRAY MO,AVIS PAGE, 1308 HIGHLAND OR, 66901
 702540089
 17 F 702 60 00

COX MO,ANNE L, PO BOX 628, 66901
 243-3100
 54 F 1902 89 P

FOWLER MO,WAYNE L, 1010.3RD PO BOX 589, 66901
 243-1560 1720470299
 23 M 1720 53 IM

MYERS MO,DANIEL L, 910 W 11TH, 66901
 243-4272 1902821356
 56 M 1902 88 GS

ORLANDO III MO,JAMES, PO BOX 628, 66901
 243-5000
 57 M 1902 89 P

RAY MO,DAVIO J, 910 W 11TH, 66901
 243-2511
 36 M 2803 91 U

RUZICKA MO,LAWRENCE J, 1115 HILLSIDE, 66901
 3005400588
 13 M 3005 46 00

STRYKER JR MO,HENRY B, 717 FIRST, 66901
 3501440999
 19 M 3501 52 00

THORNTON JR MO,FOXHALL P, 723 W 7TH, 66901
 243-1560 5101510656
 25 M 5101 55 IM

TOBIN MO,KENNETH E, 135 W 11TH PO BOX 637, 66901
 243-5005
 56 M 1902 91 PO

COUNCIL GROVE — 316
(Flint Hills Medical Society)

BLACKBURN MO,ROBERT W, RR 2 BOX 34A, 66846
 1902490040
 22 M 1902 49 00

FRESE MO,DANIEL R, 604 N WASHINGTON PO BOX A, 66846
 767-5126 1902780617
 53 M 1902 78 FP

HORNUNG MO,JOEL E, PO BOX A, 66846
 767-5126 1902850801
 59 M 1902 86 FP

SIEGLE MO,LORA A, PO BOX A C/O FMLY HLTH CNTR, 66846
 767-5126 1902841632
 56 F 1902 FP

CUNNINGHAM — 913
(Wyandotte County Medical Society)

ALLBRITTEN JR MO,FRANK F, PO BOX 177, 67035
 4101380021
 14 M 4101 54 00

DE SOTO — 316
(Ninnescah Medical Society)

WITTMAN MO,A T, PO BOX 658, 66018
 585-1177 1902761604
 00 M 87 GS

DENTON — 913
(Northeast Kansas Medical Society)

YOOER MO,EMERSON O, PO BOX 128, 66017
 1902490791
 14 M 1902 49 00

DERBY — 316
(Sedgwick County Medical Society)

NIEOEREE MO,DAVIO W, 200 S BALTIMORE AVE, 67037
 788-3741 3006820785
 56 M 3006 84 FP

SAEEO MO,MOHAMMAO, 615 B N ROCK RD, 67037
 788-5754 70404660011
 42 M 70404 81 EM

VINZANT MO,MARK N, 1410 N WOODLAWN, 67037
 788-3741 64914751614
 45 M 64914 77 FP

DODGE CITY — 316
(Ford County Medical Society)

AMAWI MO,MOHAMMAO S, 2020 CENTRAL, 67801
 227-1371 87501710073
 46 M 87501 76 GS

AYUTHIA MO,ISSARA I, 2004 FREDERICK OR, 67801
 89101670474
 40 M 89101 78 PATH

BRIAN MO,DAVIO A, 2010 CENTRAL, 67801
 227-1148 4102640191
 39 M 4102 89 OT0

CHOTIMONGKOL MO,ANUPONG, 2020 CENTRAL, 67801
 227-1371 89102690193
 43 M 89102 76 OBG

CONANT MO,MERRILL, 120 ROSS, 67801
 227-6550 1902830452
 00 M 1902 FP

CONARO MO,CLAIR C, 2020 CENTRAL, 67801
 227-1371 1902550247
 27 M 1902 55 IM

GAMBLE MO,ONNA O, 2020 CENTRAL, 67801
 227-1371 1611783961
 49 F 1611 OBG

GARCIA MD,GUILLERMO O, 1206 FRONTVIEW, 67801
 225-7710 23101680266
 43 M 23101 77 ORS

GREENBERG MO,GEORGE E, 1904 BURR PKWY, 67801
 225-1033 401680314
 42 M 401 72 R

HERRMAN MO,ADAM L, 2813 CENTER AVE, 67801
 1902740488
 48 M 1902 82 00

JOHNSON MO,HOWELL O, 2020 CENTRAL, 67801
 227-1371 1902710546
 45 M 1902 72 IM

KEISEN MO, WAYNE M, 2020 CENTRAL AVE, 67801

227-1371 4102700720
44 M 4102 89 U

KENOYER MO, M RAY, 1206 FRONTVIEW STE 201, 67801

227-6900
43 M 1902 90 GS

KYI MO, WIN M, PO 80X 1517, 67801

227-3141 20901730165
49 M 20901 GS

LYNCH MO, OARYL A, 2020 CENTRAL, 67801

227-1303 1902831084
55 M 1902 87 PO

MARPLES MO, DOUGLAS, 2020 CENTRAL, 67801

227-1371 1902800731
00 M 1902 IM

MCELHINNEY MO, CHARLES F, 2020 CENTRAL, 67801

227-1371 1902620547
36 M 1902 63 GS

MCMILLAN MO, JON M, 2010 AVE A, 67801

225-7710 2101660756
39 M 2101 87 ORS

NELSON MO, CHARLES G, 2020 CENTRAL, 67801

227-1371 1902861285
56 M 1902 89 IM

NIXON MO, JAMES E, PO 80X 1318, 67801

225-1033 4812720738
40 M 4812 79 OR

OHMAN MO, RICHARD J, 1810 1/2 FAIRWAY DR, 67801

2407410664
15 M 2407 50 00

REOBY MO, SATTI S, 808 SECONO, 67801

227-1371 49561660114
35 M 49504 77 U

SCHWARTZ MO, EUGENE W, 2100 CAROUSEL, 67801

1902500649
24 M 1902 50 00

TROTTER MO, ROGER COURTNEY, 120 ROSS BLVD, 67801

225-6120 1902741824
47 M 1902 76 FP

VIERTHALER MO, CARL A, 2020 CENTRAL, 67801

227-1371 1902781885
53 M 1902 78 IM

WILSON MO, ROBERT A, PO 80X 1000, 67801

227-1371 1902842001
54 M 1902 85 FP

WIN MO, AYE M, PO 80X 1517, 67801

227-3141 20901750115
50 F 20901 IM

EL DORADO — 316

(Butler-Greenwood County Medical Society)

AHMAO MO, ABDU Q, 123 N ATCHISON STE 302, 67042

321-7402 70403580188
32 M 16002 84 OTO

BRIAN MO, ROBERT M, 1133 W FIRST, 67042

1606300073
02 M 1606 31 00

COOPER MO, CATHY N, 119 N JONES, 67042

321-2010 1902860360
62 F 1902 FP

HAFFNER MO, WILLIAM N, 123 N ATCHISON, 67042

321-5630 1902610312
35 M 1902 62 GS

KUHNS MO, HENRY R, 123 N ATCHISON, 67042

321-2100 1902850992
59 M 1902 IM

LEE MO, YONG U, 123 N ATCHISON, 67042

321-0010 58310600081
35 M 58310 77 GS

NIGHTENGALE MO, OIANE O, 119 JONES, 67042

321-2010 1902860441
60 F 1902 FP

OLSEN MO, PHILLIP S, 123 N ATCHISON, 67042

321-2100 1902730849
46 M 1902 73 IM

REOBY MO, SUGUNA N, 123 N ATCHISON, 67042

321-7550 49562720277
47 F 49562 79 PO

REDOY MO, VENUMBAKA C, 123 ATCHISON ROOM 103, 67042

321-3300 49558710054
46 M 49511 79 IM

SHIELOS JR MO, JAMES M, 1325 W 3RD, 67042

4802421376
18 M 4802 46 00

SIWEK MO, CHRISTOPHER W, 123 N ATCHISON STE 303, 67042

321-5211 75911710013
48 M 75911 78 ORS

WHITE II MO, BENJAMIN E, 119 N JONES, 67042

321-2010 1902540993
27 M 1902 54 FP

ELKHART — 316

(Southwest Kansas Medical Society)

IWAY MO, BELINO O, 411 SUNSET 80X 878, 67950

697-2175 74811660586
42 M 74811 78 IM

IWAY MO, OLIVIA N, PO 80X 878, 67950

697-2175 74811680412
43 F 74811 80 P

PERIOD MO, DOMINADOR T, 80X 997, 67950

697-2155 74801680384
44 M 74801 75 GS

ELLINWOOD — 316

(Barton County Medical Society)

LAW MO, FINDLEY, PO BOX 668, 67526

1902510431
22 M 1902 51 00

SHIVELY MO, ROBERT M, 611 N MAIN, 67526

564-2318 1902862061
56 M 1902 89 FP

ELLSWORTH — 913

(Central Kansas Medical Society)

SEITZ JR MO, JOSEPH E, 905 CHARLES, 67439

1902460591
22 M 1902 46 00

EMPORIA — 316

(Flint Hills Medical Society)

AMENO MO, DOUGLAS J, 1127 CHESTNUT #300, 66801

343-6565 1902760039
46 M 1902 79 08G

BARNETT MO, JAMES A, 919 W 12TH, 66801

342-2521 1902790124
54 M 1902 82 IM

BERNARD MO, JOHN H, 1024 W 12TH, 66801

343-6864 1902850127
58 M 1902 88 FP

80SILJEVAC JR MO, JOSEPH E, 2522 W 15TH, 66801

343-7043 1902751650
51 M 1902 81 TS

BRAOLEY MO, H RUSSELL, 16D1 STATE, 668D1
 343-29DD 19D2610096
 35 M 1902 62 FP

BRDCKHOUSE MO, JOHN P, 16D1 STATE, 668D1
 343-29D0 19D257D06D
 31 M 1902 57 IM

BURGESDN MO, FRANK G, 1601 STATE, 66801
 342-6989 30D5650151
 40 M 3D05 71 DPH

BUTCHER MD, THOMAS P, 2D29 HUNTINGTON RD, 66801
 05 M 16D1 34 D0

CAMPBELL MD, EDWARD G, 16D1 STATE, 668D1
 343-29DD 19D261D916
 31 M 19D2 62 FP

DAVIS MO, DAVID R, 23DD INDUSTRIAL RD #1D8, 668D1
 D2 M 2101 28 D0

DICK JR MD, HENRY J, 25 W 5TH, 668D1
 342-2341 19D258D251
 27 M 1902 59 FP

EDWAROS MO, OAVID J, 16D1 STATE, 66801
 343-1191 28D369D289
 43 M 28D3 77 DRS

FDROYCE MD, NDRMAN, 1130 CHESTNUT, 66801
 343-3533 19D267D251
 41 M 19D2 67 OTD

GANN MD, E LAMDNTE, RR #2, 66801
 07 M 28D2 44 DD

GARCIA MD, GOULD C, 919 W 12TH, 668D1
 342-2521 36D758D251
 32 M 36D7 65 IM

GEITZ MD, JAMES M, 919 W 12TH, 668D1
 342-2521 19D272D509
 46 M 19D2 73 IM

GINAVAN MO, DUANE A, 1D24 W 12TH, 66801
 342-5876 19D262D27D
 35 M 19D2 63 FP

GLENN MO, JAMES N, 16D1 STATE, 668D1
 343-1191 48D466D271
 4D M 48D4 7D DRS

HICKS JR MD, THDMAS E, 1601 STATE, 668D1
 343-29D0 19D2801533
 53 M 19D2 GS

HOPPER MO, CHARLES R, 1726 DLO MANDR RE, 668D1
 17 M 19D2 47 DD

HDWELL MD, BARBARA JOYCE, 16D1 STATE, 66801
 343-29D0 34D178D9D3
 45 F 34D1 82 P0

KNECHT MO, STEPHEN M, NEWMAN HDSP 12TH & CHESTNUT, 668D1
 342-7722 19D27DD656
 44 M 1902 72 R

KRETSINGER DO, W BROCK, 919 WEST 12TH, 66801
 342-2521 2878770652
 48 M 2878 81 IM

KUMAR MD, RENU, 16D1 STATE, 66801
 342-5881 4961D790011
 55 F 4961D 82 P0

LLOYO MO, JOHN C, 1127 CHESTNUT #300, 668D1
 343-6565 48D2761088
 50 M 4814 86 D8G

MIGUELINO MO, OLIVER M, C/O NEWMAN MEM HOSPITAL, 66801
 343-6800 748D1570864
 35 M 748D1 71 PATH

MONTGOMERY MO, MICHAEL L, 16D1 STATE, 66801
 343-1191 19D2821305
 53 M 1902 86 ORS

NAGARAJU MO, ARRAMRAJU, NEWMAN MEM HOSP 12 & CHESTNUT,
 66801
 343-6800 49521730D12
 48 M 49521 84 P

NEUER MO, FREOERICK S, 12TH & CHESTNUT, 668D1
 342-7722 36D1710144
 46 M 36D1 74 R

PASTOR MO, VICTDR HUGD, 16D1 STATE STE 1D1, 66801
 342-7715 132D268D041
 43 M 132D2 78 U

PIERSON MD, MARK E, 1024 W 12TH, 668D1
 343-6864 19D28D1592
 5D M 19D2 82 FP

SCHELLINGER MO, RICHARD P, 1128 LAWRENCE, 668D1
 342-D722 3DD549D498
 22 M 30D5 56 GS

SNOWBARGER MD, MARVIN O, 16D1 STATE, 668D1
 343-29D0 19D2551D65
 29 M 19D2 55 FP

SPEARS MO, CHESTER A, NEWMAN HDSP 12TH & CHESTNUT, 66801
 343-68D0 2834761575
 50 M 2834 81 PATH

STEEVES MO, JDHN H, 1225 W 6TH, 668D1
 343-1D65 67D158D875
 32 M 67D1 R

STONE MO, CHESTER W, 1601 STATE, 668D1
 343-29DD 19D28D1037
 53 M 19D2 85 HEM

TRIMBLE SR MO, OAVIO P, 17D3 SHERWOODWAY, 668D1
 342-2572 19D232D454
 D4 M 19D2 32 OPH

UNDERWOOD MO, CHARLES C, 25 WEST 5TH, 668D1
 342-2341 19D232D462
 D7 M 19D2 32 IM

VANDER VELOE MD, STANLEY LERDY, 1527 BERKLEY, 668D1
 16 M 19D2 43 DD

WRIGHT MO, KENDALL M, 1D24 WEST 12TH, 668D1
 343-2376 19D2711232
 45 M 19D2 72 FP

ERIE — 316

(Labette County Medical Society)

BRYAN MO, EMERY C, 212 N GRANT, 66733
 D4 M 1902 32 DD

CULVER D D, SONYA KATHERINE, PD 80X 78, 66733
 244-3267 287886D112
 61 F 2878 87 FP

HANOSHY MO, STANLEY E, 324 S MAIN, 66733
 244-3291 19D279D8D9
 54 M 19D2 82 FP

ESKRIDGE — 913

(Flint Hills Medical Society)

WALKER MO, WILLIAM H, 108 SECOND AVE PO 80X 218, 66423
 10 M 24D1 4D DD

EUDORA — 913

(Douglas County Medical Society)

BOCK MO, PETER A, 101 W 10TH PO 80X 539, 66025
 542-2108 19D2842299
 57 M 1902 FP

FUNK MD, EDWARD D, RT 1/BDX 4DA, 66D25
 D4 M 1902 41 DD

HOLLAND MO, KENNETH R, PO BOX G, 66025
 582-2345 1902580430
 34 M 1902 61 FP

MCCANN MO, PATRICK E, 710 WEST 8TH, 66701
 223-3100 1902590559
 28 M 1902 60 IM

MCKENNA MO, MICHAEL J, 323 S JUOSON STE 120, 66701
 223-3950 1902640611
 38 M 1902 65 FP

NELSON MO, T EUGENE, 710 W 8TH, 66701
 223-3100 1902680728
 41 M 1902 69 FP

NICHOLS MO, ROBERT R, 902 HORTON, 66701
 223-4100 2803760741
 50 M 2803 77 FP

PAGE O O, LESLIE F, 710 W 8TH ST, 66701
 223-3100
 52 F 2878 83 08G

PARRIS MD, ROGER O, 902 S HORTON, 66701
 223-4100 2803780768
 51 M 2803 FP

PHELPS MO, OAVIO WAYNE, 902 HORTON, 66701
 223-4100 1902761060
 51 M 1902 77 FP

SCHMIOT MO, MARTY L, 710 W 8TH, 66701
 223-3100 1902881464
 62 M 1902 91 PD

SPENCER MO, JOHN HAROLO, 902 S HORTON, 66701
 223-3100 1902741051
 47 M 1902 76 FP

WEOOLE MO, DOUGLAS P, 902 S HORTON, 66701
 223-3100 1720691791
 43 M 1720 73 FP

WEILERT MO, STEVEN V, 821 BURKE ST, 66701
 223-2200
 57 M 2846 PATH

EUREKA — 316

(Butler-Greenwood County Medical Society)

CISKEY MO, WILLIAM J, PO BOX 310, 67045
 583-7401 1902730253
 47 M 1902 74 FP

SKAER MO, STANLEY ALLEN, 100 E 16TH, 67045
 583-7486 3901650828
 40 M 3901 78 GS

FORT SCOTT — 316

(Bourbon County Medical Society)

AKERS MO, GUY I, 618 MEADOW LN, 66701
 1902530017
 20 M 1902 53 00

ALOIS MO, HENRY, 6 E 13TH, 66701
 223-3100 1902410011
 13 M 1902 41 08G

ALDIS MO, WILLIAM, 1123 S CRAWFORD, 66701
 1902440026
 20 M 1902 44 00

BASHAM MO, JAMES J, 403 LEES CIR OR #103, 66701
 1902370052
 14 M 1902 37 00

BENAGE MO, JOHN F, 821 BURKE, 66701
 223-2200 1902580065
 32 M 1902 59 08G

BRAUN MO, EDWARD W, 710 WEST 8TH, 66701
 223-3100 1902680108
 42 M 1902 69 U

BURKE MO, JAMES J, 710 W 8TH, 66701
 223-3100 2834610089
 35 M 2834 67 IM

CHOW MO, STANLEY Y, 1410 S EOOY, 66701
 24222390016
 18 M 24222 63 00

DUNLAP MO, PATRICK S, 710 W 8TH, 66701
 223-3100 3005770521
 53 M 3007 79 08G

DUNSHOE MO, CARLYLE M, 710 W 8TH, 66701
 223-3100 1902570248
 32 M 1902 57 GS

DUNSHOE MO, CHERYL A, 710 W 8TH, 66701
 223-3100 1902790566
 54 F 1902 82 IM

EL-SABA MO, MEKKI M, 710 W 8TH ST, 66701
 223-3100
 40 M 52801 90 ORS

GETTLER MO, DEAN T, 710 W 8TH, 66701
 223-3100 1902570311
 31 M 1902 57 GS

GOOD MO, JAMES T, RR 1 BOX 140, 66701
 2802450322
 21 M 2802 62 00

GRANTHAM MO, HERBERT G, 701 W 8TH, 66701
 223-2200 4501760582
 49 M 4501 84 PATH

IRBY MO, PRATT, 124 S CRAWFORD, 66701
 4705360222
 13 M 4705 40 00

KERR MO, GERALD F, 701 W 8TH, 66701
 223-6164 1902690626
 44 M 1902 PATH

FREDONIA — 316

(Southeast Kansas Medical Society)

BACANI MO, OSWALDO C, 525 MADISON PO BOX 576, 66736
 378-3700 74810700312
 44 M 74810 78 GS

RINOT MO, PHILLIP L, 432 N SEVENTH, 66736
 378-3341 1902710911
 45 M 1902 81 FP

SUMNER MO, RALPH N, PO BOX 537, 66736
 378-2311 1902570914
 31 M 1902 57 FP

GARDEN CITY — 316

(Southwest Kansas Medical Society)

ARROYO MO, ZEFERINO, 603 N 5TH, 67846
 275-3700 74801670893
 00 M 74802 75 GS

BAUGHMAN MO, MICHAEL J, 603 N 5TH, 67846
 275-3700 1902820104
 56 M 1902 87 ORS

BEGGS MO, DAVID F, 603 N FIFTH, 67846
 275-3700 1902640025
 39 M 1902 65 IM

BLUMBERG MD, LAWRENCE B, 603 N 5TH, 67846
 275-3705
 43 M 3841 88 0TO

BRUNO MO, JAMES W, 1133 KANSAS PLAZA, 67846
 276-8201 4706660441
 42 M 4706 73 FP

CALBECK MO, JOHN, 603 N FIFTH, 67846
 275-3700 1902751692
 50 M 1902 78 IM

EICHHORN MD,FRANK D, BOX 719, 67846
276-8132 190256034D
25 M 1902 56 FP

FENTON MD,ROBERT M, 11D6 E HACKBERRY ST, 67846
19D2540276
20 M 1902 54 00

FRY MD,LUTHER L, 310 E WALNUT, 67846
275-7248 1902670269
41 M 1902 68 OPH

GILBERT II MD,JOHN H, 608 N FIFTH, 67846
275-3700 1902700427
46 M 1902 72 ORS

GREENWOOD MD,JAMES F, PO BOX 419, 67846
275-3700 1611650732
33 M 1611 67 FP

HALLFORD MD,JASPER C, 4TH & WALNUT, 67846
275-6111 3901520231
26 M 3901 90 EM

HANSEN MD,FRANK W, 603 N FIFTH, 67846
275-3700 1902761892
49 M 1902 78 PM

HUNSBERGER D.O.,TERRY R, 602 N THIRD PO BOX 679, 67846
275-7128 2878730502
47 M 2878 74 FP

JACKSON MD,MICHAEL D, 603 N FIFTH, 67846
275-3700 4814760214
51 M 4814 82 FP

KOKSAL MD,TOM, 1133 E KANSAS, 67846
276-8201 1902760721
00 M 1902 77 FP

LE MD,CHUONG DUC, 912 N 5TH, 67846
275-4486 94101730381
48 M 94101 83 GP

MARSHALL MD,ROBERT J, 603 N 5TH, 67846
275-3774 1611773176
44 M 1611 D

MATHEWS D O,THOMAS G, 310 E WALNUT, 67846
275-9752 2878790122
00 M 2878 OBG

MATTHEWS D O,GEORGE E, 310 E WALNUT, 67846
275-9752 2878760151
48 M 2878 83 OBG

MELIN MD,BRUCE D, 608 N FIFTH, 67846
275-6111 5605770926
51 M 5605 82 PATH

MEYERS MD,STEPHEN, 603 N FIFTH, 67846
275-3700 2834740853
48 M 2834 77 PD

MILLER MD,ROBERT E, 603 N FIFTH, 67846
275-3700 4812550646
26 M 4812 75 GS

OPPLIGER DO,ERIC R, 603 N 5TH, 67846
275-3780 2878760444
49 M 2878 78 GP

ROBERTS MD,SHELDON D, 603 N 5TH, 67846
275-3740 3840812854
55 M 3840 87 U

ROBISON MD,MASON W, 310 E WALNUT, 67846
276-2612 4002580549
26 M 4002 90 P

RODRIGUEZ MD,PAUL L, BOX 1729, 67846
275-6111 47D6660726
39 M 4706 71 R

SHULL D O,MICHAEL W, 603 N 5TH, 67846
275-3700
00 M PD

TEARE MD,MAX E, 1D07 DAVIS, 67846
276-7689 1902540934
28 M 1902 54 P

TRIDLO MD,PETER A, PO BOX 1905, 67846
275-7445 64933790361
43 M 64933 82 DR

TURNER MD,JOHN W, 1505 SPRUCE #45, 67846
19D239D584
13 M 1902 39 OD

VACHAL MD,EVA, 608 N FIFTH, 67846
275-6111 1902740941
00 F 1902 77 PATH

WACHS MD,THEODORE J, 310 E WALNUT STE 202, 67846
276-9300
34 M 3D06 90 P

WELCH MD,LAUREN A, 508 N 7TH, 67846
275-6111 1902711178
45 M 1902 72 GS

WELCH MD,MAURA S, 508 N 7TH, 67846
275-6111 1902752991
50 F 1902 78 OBG

ZAUCHE MD,JAMES T, 603 N FIFTH, 67846
275-3730 2604792421
53 M 2604 86 PD

ZELLER MD,MYRON J, 603 N FIFTH, 67846
275-3700 1902641048
38 M 1902 65 OM

GARDEN PLAIN — 316 *(Sedgwick County Medical Society)*

REINHARDT-WULF MD,TAISSIA L, PO BOX 273, 67050
91302420012
19 F 91302 60 00

GARDNER — 913 *(Johnson County Medical Society)*

NIKNIA MD,MORTEZA, PO BOX 576, 66030
884-7822 51701670187
38 M 51701 78 GS

REECE MD,A THOMEN, PO BOX 576, 66030
884-7822 1902630691
37 M 1902 64 FP

GARNETT — 913 *(Anderson County Medical Society)*

DOUGHERTY MD,THOMAS M, 117 W 6TH, 66032
448-5421 190255D301
28 M 1902 55 FP

HARRIS JR MD,CLAIB B, 101 S DAK ST, 66032
1902440646
17 M 19D2 44 00

LEITCH MD,DAVID A, GARNETT MED CTR 117 W 6TH, 66032
448-5421 190263D526
38 M 1902 64 FP

STEVENS MD,MILDRED J, 202 W 4TH, 66D32
448-5454 1902470600
23 F 1902 47 FP

GIRARD — 316 *(Crawford-Cherokee County Medical Society)*

HALL MD,WESLEY H, PD BOX 158, 66743
724-6154 19D2570361
25 M 1902 57 FP

RETHORST MD,RICHARD D, PD BOX 187, 66743
724-8D67
61 M 19D2 FP

GLASCO — 913
(Cloud County Medical Society)

HARWOOD MO, CLAUDE J, PO BOX 428, 67445
792-3210 27501521006
25 M 1902 55 00

GODDARD — 316
(Sedgwick County Medical Society)

GOODWIN MD, MARY K, PO BOX 560, 67052
794-8655 1902770506
53 F 1902 80 FP

LINO II MO, EDWARD J, PO BOX 560, 67052
794-8655 1902781036
53 M 1902 79 FP

GREAT BEND — 316
(Barton County Medical Society)

BEAHM MO, DONALD E, PO BOX 9, 67530
792-3626 1902710058
45 M 1902 72 OPH

BROWN MO, C REIFF, 3623 BROADWAY, 67530
792-1248 3901570093
31 M 3901 ORS

BROZEK MO, JEFFREY E, 1309 POLK, 67530
792-5341 1902830371
57 M 1902 84 FP

CAVANAUGH MD, CLAIR J, C K M C 3515 BROADWAY, 67530
792-2617 1803470061
23 M 1803 52 R

CAVANAUGH MO, TERRENCE J, 3515 BROADWAY, 67530
792-2617 1902820309
55 M 1902 89 R

EVANS MO, WILLIAM R, 1912 LINCOLN, 67530
1902530271
25 M 1902 53 00

FIESER MO, CARL W, 3515 BROADWAY, 67530
792-2617 1902710376
45 M 1902 75 R

FLESKE MD, LEONARD T, 1514 K 96 HWY, 67530
792-4383 1902751994
49 M 1902 75 ORS

JONES MO, EDWARD L, 3515 BROADWAY, 67530
792-2511 1902610410
35 M 1902 62 PATH

KING MO, WILLIAM T, 3421 FOREST, 67530
793-3501 1902610461
35 M 1902 62 OBG

KIRBY MO, MERLIN G, 3520 LAKIN, 67530
793-3091 1902560633
31 M 1902 56 GS

MCALLASTER MO, WENDALE E, 2111 FOREST, 67530
793-3591 1902540624
24 M 1902 54 GS

PECK MO, ROGER, PO BOX 1328, 67530
793-8429 1902810613
54 M 1902 84 IM

POLSON MO, ROBERT C, BOX A 1422 POLK, 67530
793-8414 1902420513
17 M 1902 42 OPH

PRESTON MD, RICHARD, PO BOX 1328, 67530
793-8429 1902690863
42 M 1902 70 IM

REPLOGLE MO, CHARLES B, 2111 FOREST, 67530
793-3591 1902530726
27 M 1902 53 FP

RUIZ MO, CARLOS M, PO BOX 1348, 67530
792-3210 27501521006
25 M 27501 70 P

SCHUETZ MD, PERRY N, 1422 POLK BOX A, 67530
793-8414 1902710996
45 M 1902 72 OPH

SHUKMAN MO, JAY S, 1309 POLK, 67530
792-5341 1902752737
50 M 1902 76 FP

SHIVEL MO, DAVIO G, 3523 FOREST, 67530
793-3523 1902551014
28 M 1902 55 FP

SMITH MO, PERRY MILTON, 1309 POLK, 67530
792-5341 1902771383
52 M 1902 78 FP

STANG MD, PATRICK W, 1027 JACKSON, 67530
793-9100
00 M P

YOUN MD, HWAN, 3515 BROADWAY, 67530
792-2617 58310730112
48 M 58310 82 OR

GREENSBURG — 316
(Iroquois County Medical Society)

BRALEY MO, J ROGERICK, 502 S WALNUT, 67054
723-2127 1902470081
23 M 1902 47 FP

CANNATA MO, GENE, 502 S WALNUT, 67054
723-2127 1902790337
54 M 1902 81 FP

WALOORF JR MO, MELVIN H, BRADLEY-WALDORF 502 S WALNUT,
67054
723-2127 1902470685
23 M 1902 47 FP

HALSTEAD — 316
(Harvey County Medical Society)

AILLON MO, ALEJANDRO J, 327 CHESTNUT, 67056
835-2241 26402630018
39 M 26402 74 TS

BAILEY MD, COLIN, 327 CHESTNUT, 67056
835-2241 35205590054
33 M 35205 72 GYN

BEUGELSOIJK MO, HENRY PETER, 421 SPRUCE, 67056
835-2241 1902741433
49 M 1902 77 AN

BURNETT MD, A DEAN, 504 COLLEGE, 67056
1902520119
21 M 1902 52 00

OECKER MD, DONALD D, 915 W 4TH, 67056
1902560285
31 M 1902 56 00

EASTES MD, GARY DEAN, 327 CHESTNUT, 67056
835-2241 4812710180
44 M 4812 78 U

FEOR MO, BARBARA, 327 CHESTNUT, 67056
835-2241 4814841966
52 F 4814 88 IM

FRANSEN MO, PAUL H, 4TH & CHESTNUT, 67056
835-2241 6501710065
46 M 6501 74 FP

FRIESEN MO, DOUGLAS L, 327 CHESTNUT, 67056
835-2241 1902830681
57 M 1902 GS

GNAU MO, FREDRIC B, RR 2 BOX 22AA, 67056
835-2241 1902680329
42 M 1902 69 OTO

HARMS MO,WILMER A, 327 CHESTNUT, 67056
835-2241 1902560480
22 M 1902 56 OPH

HOOFFER MO,WILFORO O, 327 CHESTNUT, 67056
835-2241 1902550549
30 M 1902 55 TS

KIMMEL MO,KENNETH K, 327 CHESTNUT, 67056
835-2241 1902770808
52 M 1902 78 IM

MALONE MO,EUGENE M, 327 CHESTNUT, 67056
835-2241 1902560684
23 M 1902 56 IM

RIZZA MO,ROBERT G, RTE 2 BOX 92C, 67056
835-2827 1201560566
30 M 1201 65 PO

SHAH MO,SHARFUOOIN, 327 CHESTNUT, 67056
835-2241 70401582981
31 M 70401 71 IM

STOFFER MO,ROBERT P, 327 CHESTNUT, 67056
835-2241 1902480451
26 M 1902 48 IM

TEJANO MO,NEONIL O A, 327 CHESTNUT, 67056
835-2241 74808661032
43 M 74808 72 ORS

WEBER MO,ROY R, 327 CHESTNUT, 67056
835-2241 1902731225
46 M 1902 74 IM

HANOVER — 913

(Northeast Kansas Medical Society)

WARREN MO,LINDA O, BOX 38, 66945
337-2214 1902700257
44 F 1902 71 FP

WARREN MO,ROGER O, 80X 38, 66945
337-2214 1902570990
31 M 1902 57 GS

HAYS — 913

(Central Kansas Medical Society)

ALBERS MO,ROBERT C, 2501 E 13TH STE 10, 67601
625-4224 1902770018
48 M 1902 82 IM

APPLEGATE JR MO,FRANCIS R, 1010 OOWNING, 67601
628-8218 1902550026
30 M 1902 55 OPH

BAUER MO,RICHARD O, 1517 E 27TH, 67601
625-0044 1902800073
54 M 1902 81 OBG

BOWERMAN MO,ROBERT F, 80X 833, 67601
628-6718 1102831582
44 M 1102 85 R

BULA MO,RALPH E, 3209A WILLOW, 67601
1902370117
12 M 1902 37 00

CARLSON MD,EARL V, ORAWER 430, 67601
628-8221 3005560071
31 M 3005 65 ORS

CECIL III MO,JOHN, BOX 833, 67601
625-6521 4804690145
43 M 4804 72 R

COOK O O, RANoy A, 105 W 13TH, 67601
628-3608 2878810247
52 M 2878 IM

COX MO,ROBERT H, 2507 CANTERBURY RO, 67601
628-3051 1902701300
43 M 1902 71 PO

OOSS MO,J RICHARD, 1517 E 27TH, 67601
625-0044 401720219
46 M 401 08G

EOOY MO,VICTOR M, 105 W 13TH, 67601
625-2551 1902550328
29 M 1902 56 GS

FENT II MO,LEE S, 2507 CANTERBURY RO, 67601
628-3051 1902700354
44 M 1902 70 PO

GATSCHET MO,TIMOTHY P, 2712 PLAZA AVE, 67601
625-3665 1902850577
50 M 1902 87 P

HAIGLER MO,JAMES P, 217 W 24TH, 67601
3006390322
13 M 3006 39 00

HALLING MO,L WILLIAM, 3000 TAM O'SHANTER, 67601
5002570175
27 M 5002 68 00

HUTCHISON MO,GLEN C, 3200 COUNTRY LANE, 67601
1902500312
21 M 1902 50 00

KANE JR MO,WILLIAM M, 2503 CANTERBURY RO, 67601
628-3245 1001540340
27 M 1001 62 OBG

KELLY MO,A CHRISTINE, 1010 OOWNING AVE, 67601
625-8553 2846770219
49 F 2846 81 GS

KIFER MO,C JAMES, BOX 833, 67601
625-6521 1902710562
45 M 1902 72 OR

LASLEY MO,MICHAEL B, 2501 EAST 13 STE 7, 67601
628-3217 1902710627
45 M 1902 76 GS

MANN MO,JOHN B, 2507 CANTERBURY RO, 67601
628-3051
59 M 1902 90 PO

MATTICK MO,IRVIN H, 2900 COUNTRY LANE, 67601
2802431077
18 M 2802 54 00

MCOONALO MO,KEVIN R, PO 80X 1176, 67601
628-6014 3006780562
52 M 3006 83 U

MCOONALO MO,THOMAS L, 1010 OOWNING AVE, 67601
628-8218 1902841217
53 M 1902 85 OPH

MYRICK MO,MICKEY C, 2509 CANTERBURY RO, 67601
628-6151 3005740702
42 M 1803 FP

NEIL MO,ROY N, 105 W 13TH, 67601
628-8341 3005650525
38 M 3005 71 PATH

NEWCOMB MD,WARO M, 1300 E 13TH, 67601
625-5646 3005710633
47 M 3005 75 PATH

NOOROHOEK MD,LYLE J, 1300 E 13TH, 67601
625-5646 1902831386
56 M 1902 84 PATH

OOM MO,OANIEL G, 1300 E 13TH, 67601
625-5646 1102841723
48 M 1102 PATH

PRASAD MO,BA8U, 2220 CANTERBURY RD, 67601
625-7301
48 M 49562 83 TR

RAJEWSKI MO,RICHARD L, 2509 CANTERBURY RO, 67601
628-6151 1902761086
51 M 1902 77 FP

RICHARDS MO,OALLAS LEE, 2501 E 13TH STE 10, 67601
625-4224 1902742359
49 M 1902 76 IM

RUTNGAMLUG MD,LUECHA, 105 W 13TH, 67601
628-6175 89101680216
40 M 89101 76 GS

SILER MD, EUGENE T, 3603 FAIRWAY DR #A, 67601

1902520607
24 M 1902 52 00

STADALMAN MD, ROSS EUGENE, 2501 E 13TH STE 7, 67601

628-3217 1902731101
47 M 1902 74 GS

STUMP MD, HARL G, 105 W 13TH, 67601

625-2551 1902650926
39 M 1902 66 GS

TAN MD, LOURDES R, 208 E 7TH, 67601

628-2871 74809670248
34 F 74811 88 P

VILLARANTE MD, FE T, 201 E 7TH, 67601

628-8251 74807630800
28 F 74807 PM

WATTS MD, HARRY E, 101D DOWNING, 67601

628-8218 702540712
27 M 702 60 OPH

WEBER MD, WALLACE N, 2707 VINE STE 10, 67601

628-3231 1902691061
43 M 1902 70 0

WERTH MD, DARRELL O, PO BOX 1176, 67601

628-6014 1902753008
50 M 1902 76 U

WILCOX JR MD, HOWARD L, PO DRAWER 430, 67601

628-8221 1902701237
44 M 1902 71 ORS

WOODS MD, GREGORY A, 2818 VINE, 67601

628-B221 1902831980
56 M 1902 84 ORS

HAYSVILLE — 316 (Sedgwick County Medical Society)

MAGSALIN MD, RDMULO O, 141 N MAIN, 67060

529-2151 74808661792
40 M 74808 78 PATH

HERINGTON — 913 (Dickinson County Medical Society)

BUSTOS MD, JDNAS G, 1005 NDRTH B, 67449

258-3705 74810680478
41 M 74810 76 GS

HESSTON — 316 (Harvey County Medical Society)

OIENER MD, CLAYTON H, 101 W VESPER, 67062

327-4122 1902540225
18 M 1902 54 GS

YOOER MD, VERNON E, ROUTE #1 BOX 136A, 67062

283-2400 4812611017
31 M 4802 68 P

HIAWATHA — 913 (Northeast Kansas Medical Society)

DUCKETT MD, THOMAS G, 201 MIAMI, 66434

1902340111
10 M 1902 34 00

HAYES MD, KRIS A, 200 DELAWARE, 66434

742-2131 1902790825
54 M 1902 81 GS

LARSON MD, DELBERT L, 314 OREGON, 66434

742-2161 1803640510
30 M 1803 66 FP

LUNDQUEST MD, DAVID E, 300 UTAH, 66434

742-2131 1902831076
54 M 1902 86 PATH

MEIOWINGER MD, RAY, 111 S FOURTH, 66434

742-2135 3005320410
03 M 3005 32 FP

SEARIGHT MD, LOWELL R, PO BOX 316, 66434

742-3523 1902810915
48 M 1902 88 FP

SINNING MD, GARY, 314 DREGON, 66434

742-2161 1902741778
49 M 1902 77 FP

HILL CITY — 913 (Central Kansas Medical Society)

REDOY MD, B N, 114 E WALNUT, 67642

674-2191 49557670024
38 M 49557 80 RT

REDDY MD, P JAGANNADHA, 80 WALNUT DR, 67642

674-2191 49511660024
42 M 49511 73 GS

HILLSBORO — 316 (Marion County Medical Society)

ENS MD, GERHARD GEORGE, 405 S WILSDN, 67063

1902550379
20 M 1902 55 DO

ENS MD, PETER D, 209 S MAIN, 67063

947-3671 1902510164
14 M 1902 51 FP

HOISINGTON — 316 (Barton County Medical Society)

MOORE MD, ROBERT, 814 NORTH ELM, 67544

653-2151 3901530504
22 M 3901 53 FP

HOLTON — 913 (Shawnee County Medical Society)

CHAVEZ MD, CARLOS A, 418 W 5TH, 66436

364-3116 64914560011
33 M 64914 GP

HARTER MD, TERRY L, 41B W 5TH, 66436

364-2126
57 M 1902 90 FP

HUTCHINS MD, JOEL R, 418 W 5TH PO BOX 466, 66436

364-2126 1902830908
49 M 1902 84 FP

HOXIE — 913 (Northwest Kansas Medical Society)

NEUENSCHWANDER MD, JOHN, 1041 15TH BOX 258, 67740

675-3292 2802510619
26 M 2802 52 FP

NEUENSCHWANDER MO, JOHN RANO, PO BOX 258, 67740
 675-3292 1902720878
 47 M 1902 73 FP

HUGOTON — 316

(Seward County Medical Society)

DAVIS O O, COOY W, 1006 S JACKSON, 67951
 544-2424
 52 M 2878 FP

HUMBOLDT — 316

(Southeast Kansas Medical Society)

LONG MO, EDWARD E, 818 BRIDGE ST, 66748
 1902500401
 21 M 1902 50 00

NEEF MO, OUG STEVENS, 202 S NINTH, 66748
 473-2275 2803840761
 57 M 2803 85 FP

HUTCHINSON — 316

(Reno County Medical Society)

AOAMS JR MO, MARCUS W, 2101 N WALORON, 67502
 669-2500 3901590027
 33 M 3901 67 PO

ALBRIGHT MO, JEROLO O, 2101 N WALORON, 67502
 669-2500 1902660026
 39 M 1902 67 FP

BARKER MO, STANTON L, 2101 N WALORON, 67502
 663-6121 1902790108
 54 M 1902 82 FP

BAUER MO, THOMAS A, 2101 N WALORON, 67502
 669-2500 1902670030
 41 M 1902 68 IM

BLACK MO, OAVIO L, 2101 N WALORON, 67502
 669-2500 1902840199
 58 M 1902 0RS

BLANK MO, JOHN N, ROUTE 5 BOX 220, 67502
 1902380058
 07 M 1902 38 00

BORRA MO, MARIO J, 804A E 43RD AVE, 67502
 2401470134
 24 M 2401 54 00

BOS MO, NORMAN C, 2606 N VANBUREN, 67501
 1611470211
 24 M 1611 61 00

CAMPBELL MO, LINDA H, 2101 N WALORON, 67502
 669-2500 1902840806
 48 F 1902 0N

CASEY MO, JAMES L, 1100 N MAIN, 67501
 669-6715 3005690080
 42 M 3005 77 PO

CESARETTI MO, LUKE S, 2101 N WALORON, 67502
 669-2500
 52 M 3401 89 OR

COSTELLO MO, J W, 1100 N MAIN, 67501
 669-6690
 00 M 0BG

CULLAN MO, GEORGE E, 2101 N WALORON, 67502
 669-2500
 53 M 3006 0BG

DAVIS MO, W O, 1100 N MAIN ST, 67501
 669-6690 1902700192
 00 M 1902 FP

DEPENBUSCH MO, FRANCIS L, 1708 E 23RD, 67502
 663-7187 1902650179
 38 M 1902 66 OPH

DOBBS MO, MICHAEL E, 1100 N MAIN ST, 67501
 669-6690
 49 M 4802 90 0BG

ECKART MD, OE MERLE E, 2517 E 45TH, 67502
 1902400181
 14 M 1902 40 00

FALTER MO, RICHARD T, 1708 E 23RD ST, 67502
 663-7187 1902670200
 38 M 1902 68 OPH

FOSS MO, DANIEL C, 2101 N WALORON, 67501
 669-2500 1902690375
 43 M 1902 70 GE

FRIESEN MO, DOUGLAS A, 1701 E 23RD, 67502
 665-2107 1902830673
 55 M 1902 83 AN

GILLAN JR MO, OALE EDWIN, 1100 N MAIN, 67501
 669-2500 1902780668
 53 M 1902 79 GS

GRAVES MO, KATHRYN, 2101 N WALORON, 67502
 669-2500 1902742146
 49 F 1902 76 0

GRINIS MO, GEORGE M, 2101 N WALORON, 67502
 669-2500 2834830551
 56 M 2834 U

HALE MO, RALPH, 37 LINKSLAND OR, 67501
 1902460183
 18 M 1902 46 00

HANSON MO, OAVIO C, 1100 N MAIN, 67501
 663-2281
 46 M 512 74 FP

HEORICK MO, KENNETH E, 2101 N WALORON, 67502
 669-2500 1902530360
 27 M 1902 53 GS

HOLZMAN MO, WALLACE O, 2101 N WALORON, 67502
 669-2500 1902540471
 28 M 1902 54 ORS

ISSINGHOFF MO, CHAO J, 2101 N WALORON, 67502
 669-2500 1902830932
 55 M 1902 PO

JARROTT MO, JOHN B, 1100 N MAIN, 67501
 669-6690 1902400300
 16 M 1902 40 ORS

JASTER MO, PAUL J, 1100 N MAIN ST, 67501
 669-6690 1902830941
 00 M 1902 FP

JOHNSON MO, RANOLE C, 1100 N MAIN, 67501
 663-2151
 46 M 1902 77 IM

KENNING MO, GERALD F, 17 BEECHWOOD LN, 67502
 669-8917 3006820483
 54 M 3006 85 AN

KLOSTERHOFF MO, BRUCE E, 1715 E 23RD, 67502
 665-2240 1611711073
 45 M 1611 72 P

LESSER MD, OANE A, 2101 N WALORON, 67502
 669-2500 3901750784
 49 M 3901 81 U

LOMASNEY MO, PATRICK J, 2101 N WALORON, 67502
 669-2500 1720821717
 55 M 1720 IM

MALLONEE MO, WILLIAM M, 2101 N WALORON, 67502
 669-2500 3901820987
 51 M 3901 N

MATLOCK MO, MARK S, 2101 N WALORON, 67502
 669-2500 3901821011
 56 M 3901 87 0

MCCOY MD, CHARLES T, 100 N MAIN STE 813, 67501
 1902410402
 16 M 1902 41 00

MCMULLEN MO, JOSEPH E, 2101 N WALORON, 67502
 669-2578 1902620563
 33 M 1902 63 GS

MILLS MO, STEPHEN C, 1100 N MAIN, 67501
 669-6690
 44 M 3901 87 OR

MULL MO, JOHN C, 2101 N WALORON, 67502
 669-2500 1902610606
 34 M 1902 OBG

NANNEY MO, GREGORY O, 2101 N WALORON, 67502
 669-2500 3901811210
 55 M 3901 86 HEM

NEUSCHAFER MO, DARREL R, 2101 N WALORON, 67502
 669-2500 1902740801
 48 M 1902 OBG

NUNEMAKER MO, MARION E, PO BOX 1129, 67504
 1902460451
 21 M 1902 46 OO

OPENSHAW MO, CALVIN R, 1824 N MAIN, 67502
 4901440251
 21 M 4901 53 OO

OYER MO, FREDERICK R, 2101 N WALORON, 67502
 669-2500 1606690904
 43 M 1606 OR

PEASE MO, GARY L, 1712 E 23RD, 67502
 662-4458 3005670585
 41 M 3005 77 OTO

PERKINS MO, JACK L, 9 PRAIRIE DUNES OR, 67502
 1902530645
 24 M 1902 53 OO

RATE MO, PEGGY S, 2101 N WALORON, 67502
 669-2500 1902730423
 46 F 1902 PO

RATE MO, ROBERT G, 2101 N WALORON, 67502
 669-2500 1902730920
 47 M 1902 IM

RICHMAN MO, OAVIO S, 2101 N WALORON, 67502
 669-2500 1902831556
 57 M 1902 FP

ROOGERS MO, CHRISTOPHER P, 2101 N WALORON, 67502
 669-2500 1902810664
 55 M 1902 FP

SAVAGE MO, RICHARD, 1100 N MAIN ST, 67501
 669-6690 3901741068
 00 M 3901 IM

SAYLOR MO, RANDOL L, 2101 N WALORON, 67502
 669-2500 1720803247
 53 M 1720 85 OPH

SCHEEL MO, BRAULEY J, 1100 N MAIN, 67501
 663-2151
 48 M 1902 GER

SELLERS O O, SCOTT, 1100 N MAIN ST, 67501
 669-6690 2879850366
 00 M 2879 FP

SHEARS MO, ROBERT N, 1100 N MAIN, 67501
 669-6715 1902441359
 20 M 1902 44 PO

SMITH MO, THOMAS WILLIAM, 1712 E 23RD, 67502
 662-4458 1643680722
 43 M 1643 80 OTO

SPITZER MO, JEROME S, 1100 N MAIN ST, 67501
 669-6690 3005590611
 00 M 3005 FP

STAFFORD MO, ROBERT W, 2101 N WALORON, 67502
 669-2500 2101691091
 43 M 2101 74 IM

STOUT MD, JAMES M, 2101 N WALORON, 67502
 669-2500 1902551111
 29 M 1902 55 FP

SUMNER MO, JOYCE R, 3011-8 NUTMEG LN, 67502
 1902510768
 26 F 1902 51 OO

SUMNER MO, MARION M, 3011 B NUTMEG, 67502
 1902520674
 26 M 1902 52 OO

TAYLOR MO, ELWYN J, 1100 N MAIN, 67501
 669-6690 1902610797
 34 M 1902 62 FP

TISOALE MO, TERRANCE C, 2101 N WALORON, 67502
 669-2500 6701610499
 36 M 6701 ORS

TWEITO MD, OAVIO H, 1100 N MAIN, 67502
 662-3364 1803640889
 38 M 1803 69 PO

WEIDENSAUL MO, O N, 2101 N WALORON, 67502
 669-2500 1902752982
 50 M 1902 76 IM

WESLEY MO, MICHAEL R, 2101 N WALORON, 67502
 669-2500 1902801291
 54 M 1902 FP

WILEY MO, CLARENCE L, 100 N MAIN STE 521, 67501
 663-8152 4301770613
 50 M 4301 86 O

WOODS MO, DENNIS O, 2101 N WALORON, 67502
 669-2500 1902861994
 60 M 1902 87 IM

WORTMAN MO, JACK A, 2101 N WALORON, 67502
 669-2500 1902620938
 34 M 1902 63 IM

INDEPENDENCE — 316 (Southeast Kansas Medical Society)

ATWOOD MO, LARRY C, PO BOX 314, 67301
 331-8610 1902800057
 54 M 1902 80 FP

BAIR MO, ALBERT E, PO BOX 925, 67301
 1902440069
 16 M 1902 44 OO

BARBERA MD, PORTER E, 700 E 81RCH, 67301
 4707460046
 19 M 4707 47 OO

CHANG MO, PHILEMON O, PO BOX 388, 67301
 331-7390 3905850503
 51 M 3905 IM

ELLIS MO, BOBBY J, PO BOX 1043, 67301
 331-7390 1902770450
 51 M 1902 89 IM

EMPSON MO, CHARLES L, PO BOX 848, 67301
 331-6019 1902680256
 37 M 1902 68 FP

KNUTH MO, KENNETH L, 2900 TERRA VISTA, 67301
 331-2200 1902500371
 22 M 1902 50 R

MASON MO, WAYNE E, PO BOX 388, 67301
 331-2200 1902610533
 36 M 1902 R

MYERS JR MO, EARL B, BOX 548, 67301
 331-3420 2803640397
 32 M 2803 69 GS

PHIPPS MD, RONNY, PO BOX 843, 67301
 331-7901 512792472
 64 M 512 82 FP

SHAH MO, ASHOK H, PO BOX 944, 67301
 331-0177 49548680173
 41 M 49548 OBG

STACEY MO, KIMBALL, 209 N SIXTH, 67301
 331-6350 1902792089
 00 M 82 IM

IOLA — 316
(Allen County Medical Society)

DICK MD, WILLIS G, 4 EAGLE DR, 66749
512410138
13 M 512 71 00

SINGER MO, GLEN O, 201 WEST ST, 66749
365-3115 1902771359
49 M 1902 FP

WOLFE MO, BRIAN O, 201 WEST ST, 66749
365-3115 1902792135
00 M 1902 FP

JUNCTION CITY — 913
(Geary County Medical Society)

BOLLMAN MD, CHARLES S, PO BOX 397, 66441
762-4575 3901660122
41 M 3901 74 GS

BRETHOUR MD, LESLIE J, 207 S EVED, 66441
238-4151 3006390136
13 M 3006 41 FP

CRAIG MO, THOMAS A, 1106 ST MARYS RD STE 204, 66441
762-4255 1902780412
53 M 1902 81 IM

MACE MD, RONALD O, 1106 S ST MARYS RD STE 305, 66441
762-4884 3901740738
42 M 3901 75 FP

O'DONNELL MO, HARRY E, 703 WEST CHESTNUT, 66441
4113420761
14 M 4113 42 00

SCOTT MO, ALEX, 835 W 5TH PO BOX 1087, 66441
238-3760 5605480448
23 M 5605 50 FP

KANSAS CITY — 913
(Wyandotte County Medical Society)

AHNEMANN MO, JANET L, 39TH & RAINBOW, 66103
588-1908
57 F 1902 90 FP

ALEXANDER MD, CHARLES E, TWO GATEWAY CENTER #917, 66101
321-6670 401700013
43 M 401 74 OBG

ALGIE MO, WILLIAM H, 7850 FREEMAN, 66112
1902270015
02 M 1902 27 00

ALLEGRE MO, ANN, 155 S 18TH ST #275, 66102
321-0341 1902771715
50 F 1902 78 IM

ALLEN JR MO, WILLIAM R, 9201 PARALLEL, 66112
334-4110 1902460027
46 M 1902 80 R

ALLEN SR MO, WILLIAM R, 9201 PARALLEL, 66112
334-4110 1902460027
22 M 1902 R

ARAKAWA MD, KASUMI, KUMC 39TH & RAINBOW, 66103
588-6670 57249530010
26 M 57211 64 AN

ARDINGER JR MD, ROBERT H, 39TH & RAINBOW, 66103
588-6311 518830040
90 M 518 90 PD

ASHCRAFT MD, SCOTT E, 39TH & RAINBOW, 66103
588-6670
59 M 1902 90 AN

ASHER MD, MARC A, KUMC 39TH & RAINBOW, 66103
588-6130 1902620024
36 M 1902 63 ORS

AUSTENFELD MD, MARK S, 39TH & RAINBOW, 66103
588-7566 1902830100
53 M 1902 89 U

BATNITZKY MD, SOLOMON, KUMC 39TH & RAINBOW, 66103
588-6835 83601640077
40 M 83601 77 DR

BAXTER MO, KIRKMAN G, 39TH & RAINBOW, 66103
588-6810 1902830207
57 M 1902 85 OR

BEATTY MO, ROBERT M, 8919 PARALLEL PKWY #331, 66112
299-9507 4901780094
52 M 4901 91 NS

BECKER MO, LESLIE E, 600 NEBRASKA STE 104, 66101
342-4010 1003460033
23 M 1003 65 U

BENNETT MO, TIMOTHY L, 39TH & RAINBOW, 66103
588-6233 1902800081
53 M 1902 88 MFM

BENSON MD, KIRK T, KUMC 39TH & RAINBOW, 66103
588-6670 1902790183
54 M 1902 80 AN

BERGIN MO, JAMES J, 8ETHANY MEO CTR 51 N 12TH, 66102
281-8767 2407540045
28 M 2407 76 IM

BISE MO, ROGER N, 39TH & RAINBOW, 66103
588-6136 1902830291
53 M 1902 83 PS

BOLING MD, J MARK, 8919 PARALLEL PKWY #314, 66112
299-6936
58 M 1902 P

BOLINGER MO, ROBERT E, KUMC 39TH & RAINBOW, 66103
588-6022 1902430110
19 M 1902 43 END

BOSILEVAC MO, FRED N, 155 S 18TH, 66102
342-4843 1902440174
16 M 1902 44 OPH

BRACKETT JR MD, CHARLES E, 460 TERRACE TRAIL EAST, 66106
3501440123
20 M 3501 52 00

BRILLHART MO, MAXINE T, 4540 COUNTY LINE RD, 66106
1902500096
15 F 1902 50 00

BROOKS MO, WILLIAM HENRY, 155 S 18TH STE 101, 66102
371-4343 1902742219
49 M 1902 78 R

CALDERON MO, JAIME, 155 S 18TH ST #275, 66102
287-5556 26401660231
39 M 26401 75 CD

CALKINS MD, JOHN W, KUMC 39TH & RAINBOW, 66103
588-6236 1902760250
51 M 1902 76 OBG

CAMERON MD, WILLIAM J, KUMC 39TH & RAINBOW, 66103
588-6246 2501540261
29 M 2501 62 OBG

CARPENTER MO, PAUL R, 155 S 18TH STE 290, 66102
371-6800 1902500126
24 M 1902 50 GS

CHAFFEE MD, TERRY L, 39TH & RAINBOW, 66103
588-6670 1902790361
53 M 1902 AN

CHALIAN MO, ALEXANDER R, 2648 MINNESOTA, 66102
3509370141
03 M 3509 57 00

CHANG MD, C H JOSEPH, KUMC 39TH & RAINBOW, 66103
588-6807 58301530011
29 M 58301 71 R

CHAVES MD, ENRIQUE, 39TH & RAINBOW, 66103
588-6371
36 M 3901 PDN

CHERNOFF MD, MARY A, 8929 PARALLEL PKWY, 66112
596-4100 1902831181
56 F 1902 84 AN

CHEUNG MO, LAURENCE Y, UKMC 39TH & RAINBOW, 66103
588-6101
44 M 38503 91 GS

CHIN MO, TOM D, KUMC 39TH & RAINBOW, 66103
588-2772 2501460233
22 M 2501 73 IO

CHO MO, CHENG T, KUMC 39TH & RAINBOW, 66103
588-6336 38501620081
37 M 38501 74 PO

CHONKO MO, ARNOLO M, KUMC 39TH & RAINBOW, 66103
588-6076 3840690244
43 M 3840 74 NEP

CLAWSON MD, O KAY, KUMC 39TH & RAINBOW, 66103
588-1400 2401520239
27 M 2401 83 ORS

COALE MD, LLOYD H, 5020 GREELEY, 66104
1902430209
13 M 1902 43 OO

COOK MO, JAMES O, 39TH & RAINBOW, 66103
588-6077 6505600141
36 M 6505 75 HEM

CORBIN MO, MURRAY O, 8919 PARALLEL STE 416, 66112
299-8000 1902650152
39 M 1902 66 CO

COVILLO O O, FREDERICK V, 155 S 18TH ST STE 214, 66102
281-5656 2878780925
49 M 2878 GS

COX III MO, IRA L, 155 S 18TH, 66102
371-4343 1902680183
43 M 1902 69 OR

CREOITOR MD, MORTON C, KUMC 39TH & RAINBOW, 66103
588-1265 3501470171
23 M 3501 86 IM

CULP MO, LOUIS M, 8919 PARALLEL PKWY STE 208, 66112
334-6801 1902530211
24 M 1902 53 FP

CUPPAGE MO, FRANCIS E, 39TH & RAINBOW, 66103
588-7070 3840590312
32 M 3840 68 PATH

DAHL MO, DAVIO C, 51 N 12TH, 66102
281-8881 4101801646
59 M 1645 90 EM

DANIELS MO, HERBERT A, 155 S 18TH STE 160, 66102
321-1161 4002750215
46 M 4002 86 ENT

DAVIS MO, CHRISTOPHER G, 1006 N WASHINGTON BLVD, 66102
299-6075 1902390118
09 M 1902 40 FP

DELCORE MO, ROMANO, 39TH & RAINBOW BLVD, 66103
588-6183 1902810974
57 M 1902 84 GS

DEMOTT MO, WAYNE R, 8929 PARALLEL PKWY, 66112
334-2500 4002590102
34 M 4002 68 PATH

DOUBEK MO, OEBRA L, KUMC 39TH & RAINBOW, 66103
588-1908 1902860491
58 F 1902 87 FP

DOJOVNE MO, CARLOS A, KUMC 39TH & RAINBOW, 66103
588-6061 13201610405
37 M 13201 73 PA

DULIN MO, JOSE I, 6013 LEAVENWORTH RO, 66104
299-0089 84711750061
51 M 84711 81 IM

DUNN MO, MARVIN I, KUMC 39TH & RAINBOW, 66103
588-6015 1902540241
27 M 1902 54 CO

EMAMI MD, ABBAS, KUMC 39TH & RAINBOW, 66103
588-6340 51703710135
45 M 51703 PO

ERENBERG MO, ALLEN, KUMC 39TH & RAINBOW, 66103
588-6339
43 M 1611 PD

ESTES MO, NORMAN C, KUMC 39TH & RAINBOW, 66103
588-6150 1902710350
40 M 1902 84 GS

EVANS MO, RICHARD G, KUMC 39TH & RAINBOW, 66103
588-3670 511750199
35 M 511 85 TR

FINLEY MO, BRENT E, KUMC 39TH & RAINBOW, 66103
588-6250 1902790639
52 M 1902 81 MFM

FORET MD, JOHN D, KUMC 39TH & RAINBOW, 66103
588-6147 1602530228
26 M 1602 59 U

FORSTER MD, JAMESON, 39TH & RAINBOW, 66103
588-6183 4101801646
52 M 4101 89 GS

FOSTER MO, FRANCES J, 4601 ORVILLE STE 12, 66102
287-2226 4707670351
41 F 4707 68 OPH

FOX MD, OEANNA K, KUMC 39TH & RAINBOW, 66103
588-6670 1902741531
48 F 1902 76 AN

FRANCISCO MO, W OAVIO, KUMC 39TH & RAINBOW, 66103
588-6129 1902440531
21 M 1902 44 ORS

GAFFNEY MD, GARY R, 39TH & RAINBOW, 66103
588-6454 1803810440
55 M 1803 86 P

GILHOUSEN MO, FREDERIC M, 1029 N 32ND, 66102
281-5252 1902660336
40 M 1902 67 ORS

GILLILANO MO, CRAIG L, 39TH & RAINBOW, 66103
588-6670 1902830720
56 M 1902 86 AN

GOLLUB MO, STEVEN B, KUMC 39TH & RAINBOW, 66103
588-6015 1205780404
53 M 1205 80 CO

GOODWIN MO, DONALD W, KUMC 39TH & RAINBOW, 66103
588-6402 1902640319
31 M 1902 76 P

GOTO MO, HIROSHI, KUMC 39TH & RAINBOW, 66103
588-6670 57241670025
42 M 57241 76 AN

GRANTHAM MO, JAREO J, KUMC 39TH & RAINBOW, 66103
588-6075 1902620300
36 M 1902 69 NEP

GREENBERGER MO, N J, KUMC 39TH & RAINBOW, 66103
588-6001 3806590249
33 M 3806 72 IM

GREENE MO, LAWRENCE S, 6013 LEAVENWORTH RO, 66104
299-2069 3506540231
33 M 3506 81 GE

GRUENDEL MO, RICHARD A, 6926 GARFIELD, 66102
299-2787 1902550441
29 M 1902 55 ORS

GRUENDEL MO, VIRGINIA T, 6926 GARFIELD, 66102
299-2787 1902550450
30 F 1902 55 OO

HALL III MD, THOMAS B, KUMC 39TH & RAINBOW, 66103
588-1330 2802690315
43 M 2802 78 IM

HANCOCK MD, ALAN C, 9201 PARALLEL, 66112
299-1474 1902640343
35 M 1902 65 FP

HARA MO, GLENN S, KUMC 39TH & RAINBOW, 66103
588-6241 514690278
43 M 514 73 OBG

HART MO, KELLY Z, 155 S 18TH, 66102
371-4343 1902752133
50 M 1902 76 OR

HARTY MO, JEAN R, KUMC 39TH & RAINBOW, 66103
588-5745 1902850721
44 F 1902 87 PO

HARWOOD MO,MICHAEL R, 8919 PARALLEL STE 206, 66112
788-7099 1611811311
55 M 1611 87 IM

HENORICKS MO,K OWIGHT, 8919 PARALLEL PKWY STE 226, 66112
299-8800 1611791212
53 M 1611 80 OPH

HENNEY MO, JANE E, KUMC 39TH & RAINBOW, 66103
588-1440 1720730916
47 F 1720 85 IM

HERMRECK MO,ARLO S, KUMC 39TH & RAINBOW, 66103
588-7232 1902650390
38 M 1902 66 GS

HIEBERT MO,JOHN M, KUMC 39TH & RAINBOW, 66103
588-6143 2405670341
42 M 2405 80 PS

HILO MO,PETER G, 39TH & RAINBOW ANES OEPT, 66103
588-6670 4802830772
57 M 4802 89 AN

HINTHORN MO,OANIEL R, 39TH & RAINBOW, 66103
588-6035 1902670404
41 M 1902 68 IO

HOAOLEY MO,WILLIAM O, KUMC 39TH & RAINBOW, 66103
588-3974 1902560536
31 M 1902 56 IM

HOLOCRAFT MO,JACQUELYNE, 155 S 18TH #160, 66102
321-1161 2105630487
36 F 2105 68 ENT

HOLLAOAY MO,FRANK P, 39TH & RAINBOW, 66103
588-6107 3006801250
53 M 64914 88 NS

HOLMES MO,FREOERICK F, KUMC 39TH & RAINBOW, 66103
588-6005 5404570350
32 M 5404 69 IM

HOLMES MO,GRACE E, KUMC 39TH & RAINBOW, 66103
588-2773 5404570368
32 F 5404 68 PO

HOOVER MO,LARRY A, 39TH & RAINBOW, 66103
588-6720
00 M 3840 90 OTO

HUERTER MO,QUENTIN C, 8919 PARALLEL STE 226, 66112
299-8800 1902590401
31 M 1902 60 OPH

HUNTER MO,VEROA J, KUMC 39TH & RAINBOW, 66103
588-6238 1611821235
54 F 1611 GYN

HUTCHISON MD,MICHAEL C, 39TH & RAINBOW ANES DEPT, 66103
588-6670 1902780854
53 M 1902 80 AN

IBARRA MO,RICHARD C, 754 PACIFIC, 66101
64902570258
26 M 64902 63 00

ILIOPOULOS MO,JOHN I, KUMC 39TH & RAINBOW, 66103
588-6197 41801690341
44 M 41801 81 GS

INGRAM MO,JOHN E, 1428 S 32NO, 66106
384-1630 3006560317
24 M 3006 57 FP

ISERN MD,HENRY J, 4601 ORVILLE STE 12, 66102
287-2226 84706780032
43 M 84706 OPH

JACOBS MO,DAVID S, 8929 PARALLEL PARKWAY, 66112
596-4725 2501560785
31 M 2501 65 PATH

JAHANIAN MO,DARYOUSH, 8919 PARALLE PKWY #304, 66112
334-5420 51701640318
40 M 51701 74 OBG

JAYARAM MO,MARANOAPALLI R, 8919 PARALLEL STE 416, 66112
299-8000 49509650135
42 M 49509 73 PO

JEWELL MO,WILLIAM R, KUMC 39TH & RAINBOW, 66103
588-6112 1611610838
35 M 1611 72 GS

JOHNSON MO,OAVIO B, 4601 ORVILLE #5, 66102
596-1313 2002790672
54 M 2002 FP

JOHNSON MO,JOHN E, 51 N 12TH, 66102
281-8814 4706430453
17 M 4706 57 PATH

JOHNSON MO,NAOINE, 8919 PARALLEL STE 325, 66112
492-6200 1903630565
38 F 1803 IM

JONES JR MO,HERMAN H, 600 NEBRASKA, 66101
342-4010 4707540287
25 M 4707 56 GS

KALIVAS MO,JAMES, 39TH & RAINBOW, 66103
588-6028 502630423
38 M 502 70 0

KEPES MO,JOHN J, KUMC 39TH & RAINBOW, 66103
588-7169 47301520146
28 M 47301 62 PATH

KERBY MO,GERALO R, 39TH & RAINBOW, 66103
588-6044 1902580499
32 M 1902 62 PUO

KHARE MD,PRATIBHA, 8929 PARALLEL PKWY, 66112
596-4100 49547710028
47 F 78 AN

KIM MO,JONG M, UKMC 39TH & RAINBOW, 66103
588-6670 58303640221
40 M 58302 74 AN

KINOSCHER MO,JAMES D, 39TH & RAINBOW, 66103
588-6670 1902820945
55 M 1902 83 AN

KING MO,CHARLES R, KUMC 39TH & RAINBOW, 66103
588-6248 1902720711
47 M 1902 73 OBG

KOVAC MO,ANTHONY L, KUMC 39TH & RAINBOW, 66103
588-6670 1902770816
52 M 1902 81 AN

KRAKER MO,OAVIO P, KUMC 39TH & RAINBOW, 66103
588-6131 1602820439
56 M 1602 88 ORS

KRANTZ MO,KERMIT E, KUMC 39TH & RAINBOW, 66103
588-6201 1606480799
23 M 1606 59 OBG

KWEE MO,SIOE T, 8929 PARALLEL PKWY, 66112
596-4723 1720630750
36 F 1720 70 PATH

KYNER MO,JOSEPH L, 39TH & RAINBOW, 66103
588-6048 1902600384
34 M 1902 61 IM

LAING MO,ROBERT R, 155 S 18TH, 66102
371-4301 1643610431
37 M 1643 62 GE

LAWWILL MO,THEOORE, KUMC 39TH & RAINBOW, 66103
588-6605 4705610296
37 M 4705 80 OPH

LEE MO,JAE M, 155 S 18TH #290, 66102
371-6800 58302650118
40 M 58302 74 GS

LEE MO,KYO R, KUMC 39TH & RAINBOW, 66103
588-6800 58302590107
33 M 58302 73 R

LEVINE MO,ERROL, KUMC 39TH & RAINBOW, 66103
588-6800 83601640191
41 M 83601 77 OR

LEVINE MO,JOSEPH M, 39TH & RAINBOW, 66103
588-6670 1902861056
60 M 1902 90 AN

LIEBERMAN MO,BRUCE IRWIN, KUMC 39TH & RAINBOW, 66103
588-5919 3843740218
49 M 3819 79 PO

LINOSLEY MO,CAROL B, KUMC 39TH & RAINBOW, 66103
588-6325 5404680848
41 F 5404 74 PO

LINDSLEY MO,HERBERT B, KUMC 39TH & RAINBOW, 66103
58B-6008 190260611
40 M 1902 74 RHU

LIU MO,ALBERT T, B919 PARALLEL STE 322, 66112
78B-9797 1902791171
49 M 1902 80 OBG

LIU MD,CHIEN, UKMC MEO CTR 39TH & RAINBOW, 66103
58B-6035 24217470036
21 M 24217 59 IO

LOWRY MO,PATRICK J, 39TH & RAINBOW, 66103
58B-6412
56 M 4705 P

LUKERT MO,BARBARA P, KUMC 39TH & RAINBOW, 66103
58B-6048 1902600422
34 F 1902 61 ENO

MACOOUALL MO,MARGARET L, KUMC 39TH & RAINBOW, 66103
58B-6074 1902771723
48 F 1902 82 NEP

MANI MO,MANI M, KUMC 39TH & RAINBOW, 66103
58B-6142 49527590131
37 M 49527 74 PS

MARTIN MO,JOSEPH P, B919 PARALLEL PKWY STE 206, 66112
334-1515 1902742294
49 M 1902 7B IM

MARTIN MO,NORMAN L, KUMC 39TH & RAINBOW, 66103
58B-6800 1902620512
36 M 1902 63 OR

MATHEWSON MO,HUGH S, KUMC 39TH & RAINBOW, 66103
58B-3341 1902440964
21 M 1902 44 AN

MATTIOLI MO,LEONE, KUMC 39TH & RAINBOW, 66103
58B-6311 56115560013
32 M 56115 69 POC

MCCARTHY MO,ROBERT P, 8919 PARALLEL STE 231, 66112
334-9003 2834530719
25 M 2834 54 U

MCCULLOCH MO,OWNA L, 51 N 12TH, 66102
281-8881
63 F 2846 90 EM

MEBUST MO,WINSTON K, KUMC 39TH & RAINBOW, 66103
58B-6146 5404580398
33 M 5404 66 U

MILLER MO,OENNIS W, 600 NEBRASKA STE 102, 66101
621-4001 4707750583
49 M 4707 82 OBG

MILLIGAN MO,ONALO B, KUMC 39TH & RAINBOW, 66103
58B-1937 2307740632
48 M 2307 75 FP

MOELLER MO,ONALO O, 4631 ORVILLE AVE #111, 66102
371-4301 1902600546
34 M 1902 61 GE

MOLOS MO,MARK A, 8919 PARALLEL STE 206, 66112
78B-7099 2846810415
57 M 2846 88 IM

MOORE MO,WAYNE V, KUMC 39TH & RAINBOW, 66103
58B-6326 2604701786
42 M 2604 74 PO

MORAN MO,JON FREDERICK, KUMC 39TH & RAINBOW, 66103
58B-2840 2802730601
46 M 2802 85 TS

MORFFI MO,RAUL R, 8919 PARALLEL STE 206, 66112
78B-7099 27501510799
25 M 27501 67 IM

MUNNS MO,STEPHEN W, 39TH & RAINBOW, 66103
58B-6133 1803791186
53 M 1803 ORS

MURPHY MO,ROBERT M, 1029 N 32ND ST, 66102
281-5252 1902690791
43 M 1902 70 ORS

MURRAY MO,JANE L, 39TH & RAINBOW FP OEPT, 66103
58B-1900 514771014
51 F 514 86 FP

NAMNUM MO,PETER A, B919 PARALLEL, 66112
78B-7099 801B20603
56 M B01 87 PUO

NELSON MO,JOHN B, 8919 PARALLEL STE 203, 66112
78B-5800 284675018B
4B M 2B46 78 PM

NIBBELINK MO,LARRY WAYNE, 8919 PARALLEL STE 440, 66112
299-2229 2846750196
4B M 2803 79 OBG

NOBLE MO,MARK J, KUMC 39TH & RAINBOW, 66103
58B-614B 2501751459
49 M 2501 81 U

NORRIS MO,CHARLEY W, KUMC 39TH & RAINBOW, 66103
58B-6700 1902640688
33 M 1902 65 OTO

O'BOYNICK II MO,PAUL LEONARD, KUMC 39TH & RAINBOW, 66103
58B-6118 1902730822
4B M 1902 79 NS

O'OEEL MO,MICHAEL L, KUMC 39TH & RAINBOW, 66103
58B-1908 1902771090
51 M 1902 83 FP

OLNEY MO,BRAO W, 39TH & RAINBOW, 66103
58B-613B 1902B10605
54 M 1902 91 ORS

OLSON MO,NANCY Y, KUMC PEO OEPT 39TH & RAINBOW, 66103
58B-6325 2846820801
58 F 2846 A

OVERFIELDO MO,A SCOTT, 155 S 18TH STE 275, 66102
621-1000 1902841381
57 M 1902 89 N

PAROO MO,LILLIAN G, KUMC 39TH & RAINBOW, 66103
58B-6371 74802620903
39 F 74802 79 PON

PAROO MO,MANUEL P, KUMC 39TH & RAINBOW, 66103
58B-6464 74801623291
35 M 74801 73 P

PAREKH MO,AJITKUMAR M, 6013 LEAVENWORTH RO, 66104
299-2069 49501710091
47 M 49501 77 PUO

PAREKH MO,MAOHAVI A, 6013 LEAVENWORTH RO, 66104
299-2069 49501710341
47 F 49501 85 FP

PARRA MO,DANIEL C, 6013 LEAVENWORTH RO, 66104
299-2069 84703750108
43 M 84703 83 FP

PARRA MO,MIGUEL O, 6013 LEAVENWORTH RO, 66104
299-2069 84710640245
37 M 84710 70 FP

PERRY JR MO,LAWRENCE L, KUMC 39TH & RAINBOW, 66103
58B-1908 1902590699
34 M 1902 73 FP

PIERCE MO,GEORGE E, KUMC 39TH & RAINBOW, 66103
58B-612B 2307600466
33 M 2307 72 TS

POTTER MO,ROBERT L, 155 S 18TH ST #275, 66102
321-0341 1902640726
38 M 1902 64 IM

POWERS MO,G ROBERT, 8919 PARALLEL PKWY, 66112
299-8000 1902650705
33 M 1902 67 FP

PREMSINGH MO,NALINI G, 1601 MEADOWLARK LN #A, 66102
596-2000 49527670020
39 F 49508 76 CO

PRESTON MD,DAVIO F, KUMC 39TH & RAINBOW, 66103
58B-6810 3841590588
33 M 3841 74 NM

PRETZ MO,JAMES B, 1300 N 81ST ST, 66112
1902470481
24 M 1902 47 OO

PRICE MO,JAMES GOROON, KUMC 39TH & RAINBOW, 66103
58B-1900 702510481
26 M 702 78 FP

PRIETO MO, JORGE N, 6013 LEAVENWORTH RD, 66104 299-2069 26401690068 45 M 26401 76 GS	SCHWORM MD, CURTIS P, 155 SOUTH 18TH, 66102 371-4343 3005730863 47 M 3005 77 DR
PROSSER MD, ROBERT L, 39TH & RAINBOW, 66103 588-6504 519740371 48 M 519 88 EM	SEGUIN MD, JOHN H, KUMC 39TH & RAINBOW, 66103 588-6337 3841801554 54 M 3841 NPM
PUGH MD, DAVID M, KUMC 39TH & RAINBOW, 66103 588-6015 801580530 29 M 801 64 CO	SHAW MO, PAMELA K, UKMC PEO DEPT 39TH & RAINBOW, 66103 588-5000 1902861544 60 F 1902 89 PD
QUICK MD, WILLIAM W, 155 S 18TH ST STE 211, 66102 43 M 3508 END	SHIREMAN MD, PETER K, 8929 PARALLEL PKWY, 66112 596-4722 2846830629 58 M 1902 87 PATH
QUINN MD, CHARLES E, 4601 ORVILLE STE 15, 66102 287-6604 4707680500 43 M 4707 75 OBG	SILLS MO, THOMAS O, 51 N 12TH, 66102 281-8400 5606771241 49 M 5606 77 EM
RALSTIN MD, JAMES H, 6013 LEAVENWORTH RD, 66104 299-2069 1902742341 49 M 1902 78 IM	SNYDER MD, THOMAS E, UKMC 39TH & RAINBOW, 66103 588-6243 1902731098 47 M 1902 82 OBG
RECKLING MD, FREDERICK W, KUMC 39TH & RAINBOW, 66103 588-6129 3545590475 34 M 3545 66 ORS	SOUCEK MO, CHARLES O, 155 S 18TH, 66102 371-4343 3005560682 31 M 3005 64 R
REOFORD MO, JOHN W 8, KUMC 39TH & RAINBOW, 66103 588-6795 6501530164 28 M 6501 74 PM	SPEER MO, LELANO, 910 N WASHINGTON, 66102 1902360511 12 M 1902 36 00
REOMON DO, MARY L, KUMC 39TH & RAINBOW, 66103 588-1908 2878830370 44 F 2878 FP	SPIEKER MD, JOHN B, 3900 RAINBOW, 66103 588-6670 57 M 4802 90 AN
REEB MO, RONALD JOSEPH, 155 S 18TH, 66102 371-4343 3006720870 46 M 3006 79 DR	STECHSCHULTE MO, DANIEL J, KUMC 39TH & RAINBOW, 66103 588-6008 2834620921 36 M 2834 73 A
RHOODES MO, JAMES B, KUMC 39TH & RAINBOW, 66103 588-6019 1902580766 28 M 1902 66 GE	STEELE MO, CLARENCE H, 8009 NE 8RASKA, 66112 1902400474 14 M 1902 40 00
RICE JR MO, FREDERICK A, 1029 N 32ND ST, 66102 281-5252 4802630641 36 M 4802 68 ORS	STEER MO, PHYLLIS L, 39TH & RAINBOW, 66103 588-6670 1902851778 57 F 1902 89 AN
RILEY MO, RAY 8, 2020 ORVILLE, 66102 1902360448 06 M 1902 36 00	STEHR MO, CHRISTIAN H, 51 N 12TH, 66102 281-7774 1643670786 41 M 1606 AN
ROBINSON MO, RALPH G, KUMC 39TH & RAINBOW, 66103 588-6810 1902620768 37 M 1902 63 NM	STRICKLAND MO, JULIE L, KUMC 39TH & RAINBOW, 66103 588-6230 2803840647 58 F 2803 OBG
ROOK MO, LEE E, 1111 S 55TH, 66106 1902380490 09 M 1902 38 00	STUBBLEFIELD MO, CHARLES T, 8919 PARALLEL STE 440, 66112 299-2229 1902580936 32 M 1902 59 OBG
ROSENBERG MO, ALLAN J, KUMC 39TH & RAINBOW, 66103 588-6354 2407620812 38 M 2407 PO	STUBBLEFIELD MD, JENNIFER L, 8919 PARALLEL STE 440, 66112 299-2229 1902851719 59 F 1902 86 OBG
ROSENTHAL MD, STANTON J, KUMC 39TH & RAINBOW, 66103 588-6800 1902710953 46 M 1902 72 OR	TEMPLETON MD, ARCH W, KUMC 39TH & RAINBOW, 66103 588-6805 3005570661 32 M 3005 69 R
ROTH MO, ALAN E, 8ETHANY HOSP 51 N 12, 66102 281-8867 1902620776 35 M 1902 63 PATH	THEROU MO, LEONA F, KUMC 39TH & RAINBOW, 66103 588-5908 6701670190 41 F 6701 71 PD
RUBLE MO, REBECCA A, KUMC 39TH & RAINBOW, 66103 588-1908 1902821666 56 F 1902 90 FP	THOMAS MD, JAMES H, KUMC 39TH & RAINBOW, 66103 588-6115 2012660629 41 M 2012 75 GS
RUTH MD, WILLIAM E, 39TH & RAINBOW, 66103 588-6044 1902530793 26 M 1102 53 PM	THOMAS MO, THOMAS V, 155 S 18TH ST STE 214, 66102 371-7676 49549610021 37 M 49549 72 GS
SANDERS MD, JAMES E, KUMC 39TH & RAINBOW, 66103 588-1908 1902861471 51 M 1902 90 FP	THOMPSON MO, OANNIE M, TWO GATEWAY CTR STE 917, 66101 321-3355 4707640583 35 M 4707 68 OBG
SANTOS MO, FERMIN M, 155 S 18TH STE 225, 66104 321-1133 84706760686 49 M 84706 82 P	TICKLES MO, DEBRA F, 8919 PARALLEL STE 326, 66112 299-8300 1902841829 56 F 1902 89 PD
SCHLOERB MO, PAUL R, 39TH & RAINBOW, 66103 3545440465 19 M 3545 55 GS	TIOJANCO MO, REYNALDO R, 6013 LEAVENWORTH RD, 66104 299-2069 74801652437 44 M 65 FP
SCHWEGLER MO, RAYMOND A, 8919 PARALLEL PKWY STE 416, 66112 299-8000 1902630747 37 M 1902 64 CO	TOBY MO, EDWARD 8, 39TH & RAINBOW BLVD, 66103 588-6134 55 M 1720 91 ORS

TORLINE MO, RONALD L, KUMC 39TH & RAINBOW, 66103
588-6670 1902841837
58 M 1902 85 AN

TRUEWORTHY MD, ROBERT C, KUMC 39TH & RAINBOW, 66103
588-6340 2802660742
40 M 2802 73 PD

TUCKER MD, VIRGINIA L, 39TH & RAINBOW PEO DEPT, 66103
588-5919 1902570965
30 F 1902 57 PD

UNRUH MO, GREGORY K, KUMC 39TH & RAINBOW, 66103
588-6670 1902810923
55 M 1902 82 AN

VARGHESE MO, GEORGE, KUMC 39TH & RAINBOW, 66103
588-6944 49552700197
44 M 49509 77 PM

VATS MD, TRIBHAWAN S, KUMC 39TH & RAINBOW, 66103
588-6340 49529630033
40 M 49529 75 PD

WARNOCK MO, JULIA K, 39TH & RAINBOW, 66103
588-1330 4706841925
51 F 4706 88 P

WEATHERSTONE MD, KATHLEEN S, 39TH & RAINBOW, 66103
588-6337 1902831904
54 F 1902 90 PD

WEED MO, JOHN C, 39TH & RAINBOW, 66103
588-6244 2101681231
43 M 2101 86 GYN

WEIGEL MD, JOHN W, KUMC 39TH & RAINBOW, 66103
588-6147 1902540977
29 M 1902 54 U

WIBLE MD, KENNETH L, KUMC 39TH & RAINBOW, 66103
588-5908 4102691691
43 M 4102 87 PD

WILLIAMSON MD, STEPHEN K, 39TH & RAINBOW, 66103
588-6029
54 M 1902 89 IM

WILSON MD, DAVID B, KUMC 39TH & RAINBOW, 66103
588-6015 4706801001
54 M 4706 81 IM

WISE MD, JOSEPH E, 8919 PARALLEL STE 326, 66112
299-8300 1902761582
51 M 1902 PD

WOLF MD, KARL T, 621 NORTHRUP, 66101
1902480541
14 M 1902 48 00

ZINN MD, THOMAS W, 155 S 18TH, 66102
371-4343 1902671001
41 M 1902 68 R

KANSAS CITY MO — 816

AHMED MO, IFTEKHAR, 2900 BALTIMORE #390, 64108
756-2651 89519740019
45 M N

AMINI MD, JAFAR, 4900 SHOPE PKWY, 64130
923-5800 51701621658
37 M 51701 R

BRIDGENS MD, JAMES G, 1025 HUNTINGTON RD, 64113
363-1123 1902470090
22 M 1902 47 PATH

BRUMMETT MD, RICHARD R, 2300 MAIN ST STE #1090, 64108
221-0222 1902640084
34 M 1902 65 FP

CHRISTENSEN MD, SHANE R, 4822 RIDGEWAY CT, 64133
281-8881 2846790074
55 M 1902 83 EM

CULLAN MD, SAMUEL K, 5600 NE ANTIOCH RD, 64119
861-7600
54 M 3006

DAVIS MD, RICHARD E, 1010 W 56TH, 64113
1902540209
26 M 1902 54 00

DEVINS MD, GEORGE S, 6700 TROOST #520, 64131
36 M 1902 62 IM

GODFREY MD, WILLIAM A, 4320 WORNALL, 64111
561-2289 1902650284
38 M 1902 66 OPH

GRAHAM MD, BRUCE D, 6420 PROSPECT STE T-311, 64132
333-8688
51 M 2803 87 GS

GRAHAM MD, JAMES R, 8880 WARD PKWY, 64114
333-9700 1902701342
43 M 1902 FP

HARD MD, BENJAMIN F, 8400 HAWTHORN RD, 64120
242-2525 4802550664
28 M 4802 64 OM

HATHAWAY MO, PETER, 1010 CARONOELET DR #105, 64114
941-2121 3503600195
31 M 3503 74 IM

HOPKINS MO, JAMES P, 6650 TROOST, 64131
523-7811
22 M 2407 85

HUNKELER MO, JOHN O, 4321 WASHINGTON ST #6000, 64111
41 M 1902 85 OPH

KEITGES MD, PIERRE W, 1010 CARONDELET, 64114
942-8100
33 M 3006 72 PATH

KINORE MD, LYNN H, 4320 WORNALL RD STE 40-II, 64111
531-5510
37 M 1902 CO

KINPORTS SR MD, EDWARD S, PO BOX 1823, 64141
1602420309
15 M 1602 77 00

KLEMM MD, J MARTIN, 4320 WORNALL RD #702, 64111
661-9669 1902780943
53 M 1902 80 P

LUETJE MD, CHARLES MARION, 3100 BROADWAY STE 509, 64111
531-7373
41 M 2803 78 OTO

MATHEWS MD, DAVID R, HBC #3 PO BOX 9627, 64134
966-5011 1902781150
53 M 1902 80 FP

PAYNE MD, J RALPH, 4460 ROCKHILL TERR, 64110
561-2930 1902660808
40 M 1902 67 EM

REIVICH MD, RONALD S, 1000 E 50TH ST #270, 64110
383-3050 3806600601
34 M 3806 66 P

RISEING MD, JESSE D, 10000 WORNALL RD #2107, 64114
588-1934 1902380481
14 M 1902 38 IM

SCHLOZMAN MD, DANIEL L, 6420 PROSPECT STE T303, 64132
333-1919
38 M 1902 PM

SUTTON MD, ROBERT E, 100 W 31ST, 64108
931-1290 1902721114
46 M 1902 73 FP

THALBLUM MD, HARVEY, 6400 PROSPECT STE 310, 64132
523-2400
39 M 1103 R

UTLEY MD, JAMES HARMON, 4951 WESTWOOD TERR, 64112
281-8881 1606741941
51 M 1606 77 EM

WOLFF MD, FREDERICK P, 11549 BALTIMORE AVE, 64114
1902441600
20 M 1902 44 00

YOST JR MD, JOHN G, 6420 PROSPECT STE T207, 64132
444-9000
53 M 3005 ORS

ZARR MD,JAMES S, 6675 HDLMES ST #410, 64131
276-7035 2803811108
55 M 2803 86 PM

KINGMAN — 316
(Ninnescah Medical Society)

BOYER MD,ROBERT E, 760 WEST D, 67D68
532-5145 190262DD59
36 M 1902 63 FP

BURKET JR MD,GEORGE E, SPRING LAKE RT 1, 67D68
19D2370125
12 M 19D2 37 00

KINSLEY — 316
(Iroquois County Medical Society)

ATWOOD MD,M DALE, 4D9 ELIZABETH AVE, 67547
19D2510032
19 M 1902 51 00

BAKER DO,ROBERT R, PO BOX 8, 67547
659-5179 2878780798
5D M 2878 79 FP

SCHNOEBELEN MD,RENE E, 416 E 4TH, 67547
659-2141 39014D0384
16 M 3901 46 FP

LA CROSSE — 913
(Barton County Medical Society)

BHARGAVA MD,ASHOK KUMAR, PD BOX 49D, 67548
222-2564 49547640119
37 M 49547 78 FP

BHARGAVA MD,SHOBHANA, PO BOX 490, 67548
222-2564 49547640135
38 F 49547 81 FP

LAKIN — 316
(Southwest Kansas Medical Society)

WAMSLEY MD,CRAIG A, 506 THORPE BOX 744, 67860
355-7550
58 M 19D2 FP

LANE — 913
(Miami County Medical Society)

BILLINGSLEY JR MD,JOHN A, RR 1 BDX 55A, 66D42
1902580090
31 M 1902 59 00

LARNED — 316
(Barton County Medical Society)

COOK MD,KAROLYN M, 923 CARROLL, 67550
285-6993
61 F 1902 90 FP

CODK MD,THEODORE R, 923 CARRDLL, 67550
285-6993
61 M 19D2 90 FP

CRAM JR MD,OLE R, 915 W 6TH, 67550
1902430233
18 M 1902 43 00

DOUGHERTY JR MD,THOMAS M, 916 W 2ND, 67550
285-6993
56 M 19D2 89 FP

JDNES MD,DAVID B, PO BOX 68, 67550
285-3133 19D284D962
58 M 19D2 87 GP

SHAH MD,MIAN, SHAH CLINIC PO BOX 30, 67550
285-3173 16DD258DD32
32 M 7D403 76 GS

SHAH MD,NASREEN, SHAH CLINIC PO BOX 30, 67550
285-3173 7D409620068
39 F 70409 76 0BG

SMITH MD,JOHN D, PO BDX 269, 67550
3901510554
22 M 39D1 52 00

LAWRENCE — 913
(Douglas County Medical Society)

BAILEY MD,WILLIAM A, PO BOX 127, 66044
843-9125 1902660051
40 M 19D2 67 DRS

BEACH MD,RICHARD R, 324 WOODLAWN DR, 66044
28D2480043
23 M 2802 54 00

BELOT JR MD,MDNTI L, LAWRENCE NATIONAL BK BLDG, 66044
843-3640 19D2400032
13 M 1902 40 FP

BISHOP MD,RODNEY LEE, 3310 CLINTON PKY CT, 66044
842-7200 1902751625
49 M 19D2 75 IM

BOYOEN MD,MARY S, 4004 TRAIL RO, 66049
842-3778 26D4390144
14 F 2604 42 POA

BRANSDN MD,VERNON L, 346 MAINE, 66044
842-4477 1902420076
17 M 1902 42 PD

BRUNFELDT MD,JOAN KRAUS, 404 MAINE, 66D44
842-3635 19D277D2D4
52 F 19D2 78 IM

BUCK JR MD,HENRY W, WATKINS MEM HSDP, 66D45
864-9500 1902600121
34 M 19D2 61 DBG

CARNAHAN MD,ROBERT L, 1112 W 6TH, 66044
841-4310 190270D109
42 M 19D2 IM

CHEDIAK MD,ELIAS, 601 MISSOURI, 66D44
841-743D 84704650344
39 M 847D4 71 P

CULVER MD,WARREN T, 3506 W TENTH, 66044
350846D251
20 M 35D8 67 00

DENNING MD,DALE P, 346 MAINE, 66044
842-6644 1902820422
56 M 19D2 83 IM

DINSDALE MD,ROBERT C, 1112 W 6TH STE 216, 66044
841-11D7
58 M 4812 90 0TO

DUNLAP MD,RICHARD L, 711 SUNSET DR, 66D44
842-4344 3005370247
12 M 30D5 38 EENT

FLDERSCH MD,HUBERT M, 1915 QUAIL RUN, 66046
19D2350124
D8 M 1902 35 00

FORTIN MD,DAVID, 1112 W 6TH ST #1D8, 66044
841-3211 19D2700397
OD M R

FRIESEN MD, DALE, PD 80X 521, 66044 842-7026 1902740305 47 M 1902 75 AN	MITCHELL MD, ALEX C, 1626 W 20TH, 66044 843-4739 1902500452 18 M 1902 50 PH
FULBRIGHT MD, THOMAS W, 1112 W 6TH STE 210, 66044 865-5995 1902850542 56 M 1902 90 FP	MODDRELL MO, CAROL A, 404 MAINE, 66044 749-6100 1902710023 45 F 1902 72 PATH
GILLES MO, HELEN M, 1301 IOWA, 66044 1902450277 22 F 1902 45 DO	MYRICK MD, STEPHEN W, 346 MAINE, 66044 842-6644 1902771049 52 M 1902 78 GS
GODWIN MD, PHILLIP A, 500 RDCKLEDGE, 66049 841-6540 1902550425 28 M 1902 55 AN	NELSDN MD, RICHARD O, 2425 DRCHARD LANE, 66044 1001410403 11 M 1001 41 OO
HAGGAN MD, MARGARET E, 1746 N H, 66044 250142D355 0D F 2501 69 OO	O'NEAL MO, LYNN W, 1112 W 6TH #202, 66044 841-2280 1902771111 51 M 1902 86 OPH
HASSELLE III MD, JAMES E, 346 MAINE, 66044 841-1243 47D6590621 35 M 4706 69 P	OELSCHLAGER MD, RONALD O, 1112 W SIXTH, 66044 841-3211 1902690812 43 M 1902 70 R
HATTON MO, DONALD W, 404 MAINE STE 3, 66044 842-3635 1902680353 42 M 1902 69 IM	ORCHARO MD, RICHARD A, 1112 W 6TH STE 202, 66044 841-2280 2802680549 41 M 2802 74 OPH
HIEBERT MO, DAVIO L, 1112 W SIXTH, 66044 841-3211 1902610371 36 M 1902 62 R	OSBERN MD, LIDA, 404 MAINE, 66044 842-3635 1902771120 52 F 1902 77 IM
HIEBERT MD, JOHN 8, 404 MAINE, 66044 841-3636 1902680370 40 M 1902 72 CO	PEES JR. MO, GERALD 8, 2200 HARVARO RO, 66044 843-5160 1902710864 45 M 1902 72 IM
HIDFFMAN MD, J PHILIP, 404 MAINE, 66044 842-3635 1902780811 00 M 1902 IM	PHIPPS MO, CARLA 8, 500 ROCKLEDGE RO, 66044 841-6540 1902851417 55 F 1902 FP
HIDFFMANN MD, MARY A, 543 LAWRENCE AVE STE D, 66049 799-2994 2846780311 54 F 2846 8D ORS	PLACEK MD, DEBRA C, 346 MAINE, 66044 843-0677 3005781000 54 F 3005 08G
HUGHES MO, ROBERT W, 346 MAINE, 66044 843-1374 1902540489 27 M 1902 54 FP	PRAEGER MD, MARK A, 1112 W 6TH STE 204, 66044 843-2D1D 1902680817 42 M 1902 69 GS
INGHAM JR MD, H LAIRD, 404 MAINE STE 3, 66044 842-3635 3901700540 45 M 3901 73 IM	PRICE JR MD, LAURANCE W, 2404 ORCHARD LN, 66049 749-6169 1902590711 33 M 1902 60 PATH
JONES MD, H PENFIELD, MED ARTS CTR 346 MAINE, 66044 24D131D650 D6 M 24D1 33 GS	REEO MD, JAMES S, WATKINS MEMORIAL HOSP, 66045 843-4455 1902470499 23 M 1902 47 FP
JOSEPH MO, HOWARD F, 308 MAINE, 66044 843-3981 1902510377 26 M 1902 51 U	REESE MO, JOHN L, 2417 PRINCETON 8LVO, 66044 190261D657 35 M 1902 62 OD
KENNEDY MD, L ELAINE, 404 MAINE, 66044 842-3635 1902820929 00 F IM	RIORDAN MD, TERRANCE, 346 MAINE, 66044 842-4477 1902771260 51 M 1902 83 AOL
LANGE MO, MICHAEL, 1112 W 6TH STE 110, 66044 842-7026 00 M AN	ROBERTS MD, RICHARD S, 342 WOODLAWN OR, 66044 2802440785 19 M 2802 46 OO
LEARNEO MO, GEORGE R, 401 ARKANSAS, 66044 843-55D2 1902550701 22 M 1902 56 GS	ROCK MO, RANOALL W, WATKINS MEM HLTH CNTR UKMC, 66045 864-9500 1902831572 0D M 1902 FP
LOVELAND MO, G CHARLES, 346 MAINE, 66044 842-4477 190273D695 47 M 1902 74 PD	RUNOQUIST MO, BETH, 346 MAINE, 66044 842-4477 1902851549 58 F 1902 PO
MADSEN MO, GLENN L, 1112 W SIXTH, 66044 841-3211 3005650479 38 M 3005 68 R	SANDERS MD, J ALAN, LAWRENCE CL LAB 404 MAINE, 66044 842-2083 19026D0716 29 M 1902 62 PATH
MAGEE MD, LAWRENCE M, RR #1 8DX 178AC, 66044 864-95DD 19D2770913 52 M 1902 79 FP	SCHNDSE MD, GREGORY D, 2200 HARVARD RD, 66044 843-5160 1902761205 51 M 1902 77 IM
MANAHAN MD, G EUGENE, 2129 TERRACE RD, 66044 1902440913 19 M 1902 44 OD	SCHROEOER MD, SYONEY O, 902 W 25TH, 66044 1902441324 18 M 1902 44 OO
MCGINNESS MD, MARILEE K, 1112 W 6TH STE 2D4, 66044 843-2D10 39D582D116 54 F 3905 88 GS	SCHWEGLER MD, RAYMOND A, 1504 UNIVERSITY OR, 66044 2604310884 07 M 2604 35 OO
MCRAE-DENNING MD, PATRICIA, WATKINS HLTH CENTER, 66045 864-850D 19D2821208 56 F 1902 83 IM	SEGE8RECHT MO, STEPHEN L, 1112 WEST 6TH, SUITE 216, 66044 841-1107 19D2800936 55 M 1902 OTO

SOSINSKI MD,RICHARD F, 2200 HARVARO RD, 66049
843-5160
51 M 1902 77 IM

STEIN MD,MATTHEW, 3310 CLINTON PK CT, 66047
842-7200 2803770983
49 M 28D3 DN

TILSON MO,WAYNE R, 325 MAINE, 66044
749-6100 5404771380
49 M 5404 78 EM

VERNON MD,MARY C, 500 ROCKLEOGE, 66044
841-6540 1902771529
52 F 1902 78 FP

VIERTHALER MO,STEPHEN L, 545 COLUMBIA OR, 66049
832-1424 1902771693
51 M 1902 78 OBG

WELL MO,MICHAEL A, 1112 W 6TH STE 106, 66044
749-0639 1606671128
41 M 1606 74 U

WERTZBERGER MD,JOHN, 1112 W 6TH PO BOX 127, 66044
843-9125 1902630909
36 M 1902 64 ORS

WOLLMANN MD,MARTIN, 2615 ORCHARD LN, 66044
1902571058
26 M 1902 70 00

LEAVENWORTH — 913 (Leavenworth County Medical Society)

DIALLO MD,GASTON I, 113 DELAWARE STE E, 66048
682-9030 86905630182
35 M 86905 75 GE

OUYSAK MD,SAMI, 920 6TH AVE, 66048
682-2424 90201470471
22 M 90201 IM

GRAHAM MO,KENNETH L, RTE 2 BOX 182AA, 66048
3840450243
21 M 3840 48 00

GRISOLIA MD,ANORES, 210 ELM, 66048
84708500011
27 M 84708 63 00

HALLER MD,CHRIS C, 4101 S 4TH ST TRFWY, 66048
682-2000 1902800448
55 M 1902 81 GS

HAMMEKE MO,JOHN C, 3601 S 4TH ST TRAFFICWAY, 66048
682-5201 401610308
27 M 401 66 OPH

JOHNSON MO,PAUL O, 221 OELAWARE #A, 66048
682-2240 1902610401
36 M 1902 64 FP

MCALLASTER MO,CLAUDIOA, 4500 S 4TH, 66048
682-4771 1902771197
52 F 1902 79 PO

MCCOLLUM MO,WILLIAM B, 920 6TH, 66048
682-1466 1902660671
41 M 1902 68 TS

MENGEL MD,CHARLES E, 3221 MEADOW RO, 66048
682-2000 2307570362
31 M 2307 88 IM

MERRITT MD,W HENRY, 1808 WESTWOOD DR, 66048
702390265
14 M 702 58 00

MILLS MO,VERNON A, 4514 S 4TH ST TRFWY, 66048
727-6046 1902770981
51 M 1902 80 PO

PALMER MD,MARVIN M, 4512 S 4TH TRAFWY, 66048
727-1151 702710634
45 M 702 77 OBG

RABE MD,MELVIN A, 600 S BROADWAY, 66048
1902370478
14 M 1902 37 00

SILVA MO,CATHERINE, 4224 LAKEVIEW DR, 66048
684-6350 1902800961
54 F 1902 90 FP

SNOW MD,DONALO L, 1127 VILAS, 66048
64904540020
21 M 64901 62 00

STEVENS MO,LEAH J, 920 6TH AVE, 66048
682-2424 1902810214
55 F 1902 FP

STRUTZ MD,WILLIAM C, 1918 WESTWOOD DR, 66048
682-8868 5606431246
08 M 5606 59 R

VOORHEES MO,CARROLL O, 2510 GIRARO, 66048
1902520739
25 M 1902 52 00

VOORHEES MO,GORDON S, 1914 WESTWOOD OR, 66048
642-6661 1902390606
12 M 1902 39 IM

WASHBURN MD,MICHAEL E, 4516 8 SOUTH 4TH, 66048
727-2194 4705730542
47 M 4705 GS

LEBO — 316 (Flint Hills Medical Society)

HUTCHISON MD,JOE R, BOX 303, 66856
256-6346 1902830916
55 M 1902 86 FP

LENORA — 913 (Northwest Kansas Medical Society)

STEICHEN MO,EOWARD F, BOX 97, 67645
1601310941
05 M 1601 31 00

LEOTI — 316 (Southwest Kansas Medical Society)

JUBAY JR MD,FELIPE L, 411 S FOURTH, 67861
375-2222 74811720511
49 M 74811 81 GP

LIBERAL — 316 (Seward County Medical Society)

ALLEN MD,RAY E, 2 PLAZA DR, 67901
624-5691 1902630020
37 M 1902 64 IM

CAEDO MO,CARMELITA D, 2401 LILAC OR, 67901
624-1651 74801634196
41 F 748D1 77 R

ESTRADA MD,EDMUNDO C, 1D2 E 11TH, 67901
624-2565 74801671938
43 M 74801 80 GS

GRIMES MD,I ROSS, PO BOX 2856, 67905
624-1676 390154D283
27 M 3901 61 TS

HOLCOMB MO,WILLIAM M, 15 E 11TH, 67901
624-2252 3901560292
31 M 3901 63 GS

KNUOSEN MD, DENNIS, BOX 2529, 67905
624-3811 1803760850
00 M GS

KOONS MD, JESS W, PO BOX 2886, 67901
 624-3841 1902570469
 27 M 1902 57 OPH

NEVINS MD, RICHARD L, 1410 WESTERN AVE, 67901
 624-0255 3901730902
 47 M 3901 75 FP

PALMER MD, H C, PO BOX 2347, 67901
 624-5691 1902630640
 36 M 1902 64 IM

PATRON MD, RICARDO A, 222 W 15TH ST PO BOX 2529, 67901
 624-3811 74808570207
 31 M 74808 83 08G

PETERSON MD, HUBERT C, PO BOX 1340, 67905
 624-1651
 43 M 401 PATH

REESE MD, JACK O, 15 E 11TH, 67901
 624-6226 1902570698
 32 M 1902 57 FP

WAOE MD, THEODORE E, 318 N LINCOLN, 67901
 512300472
 04 M 512 57 00

ZAINALI MD, ASSA OLLAH, PO BOX 1891, 67901
 624-1651 51701720249
 46 M 51701 79 R

LINCOLN — 913 (Central Kansas Medical Society)

MEOUNA MD, LEO L, PO BOX 467, 67455
 524-4476
 56 M 3005 FP

LINDSBORG — 913 (McPherson County Medical Society)

CARLSSON MD, E R, PO BOX 109, 67456
 227-2818 1902440271
 00 M 1902 IM

FREDRICKSON MD, OUANE E, 121 W LINCOLN, 67456
 227-3371 1902660310
 39 M 1902 67 FP

MURFITT MD, MALCOLM C, 125 W STATE, 67456
 801410375
 13 M 801 46 00

LYNDON — 913 (Franklin County Medical Society)

MARCELL MD, GERALD W, 710 TOPEKA, 66451
 828-3143 1902831122
 46 M 1902 89 FP

STOUT MD, NILES M, 66451
 828-4521 1902500711
 16 M 1902 50 FP

LYONS — 316 (Rice County Medical Society)

GRIMES MD, JAMES T, 1221 W NOBLE, 67554
 257-5124 1902530319
 27 M 1902 53 FP

SIEMENS MD, RICHARD A, 1221 W NOBLE, 67554
 257-5124 1902590826
 30 M 1902 60 FP

STRINGFIELD MD, SCOTT L, 1221 W NOBLE, 67554
 257-5124 1902841756
 57 M 1902 88 FP

TORIAS MD, ROGER R, 1221 W NOBLE, 67554
 257-5182 1902761400
 51 M 1902 82 FP

MANHATTAN — 913 (Riley County Medical Society)

BAKER MD, RICHARD B, 2600 ANDERSON, 66502
 537-4200 4113680062
 42 M 4113 76 ORS

BAMBARA MD, JOHN F, 1133 COLLEGE, 66502
 539-5363 1902751561
 46 M 1902 88 PATH

BARLOW MD, JOHN M, 1133 COLLEGE, 66502
 539-3504 1102710050
 45 M 1102 81 OTD

BASCOM MD, GEORGE S, 1133 COLLEGE, 66502
 539-5341 2401520077
 27 M 2401 59 GS

BIBERSTEIN MD, GREG, 1133 COLLEGE AVE, 66502
 537-9030 1902842248
 00 M 1902 PO

BOESE MD, KENNETH M, 1825 ALABAMA LN, 66502
 776-4744 1902560145
 25 M 1902 56 FP

BOXER MD, GARY, 205 S SETH CHILDS RD STE 4, 66502
 776-8484
 00 M P

CATHEY MD, ROBERT H, 1133 COLLEGE, 66502
 537-7990 1902680167
 42 M 1902 69 0

CRANE MD, CHARLES H, 720 CANFIELD DR, 66502
 3520460151
 22 M 3520 62 00

DURKEE MD, WILLIAM R, 440 OAKDALE, 66502
 1902450234
 23 M 1902 45 00

FISCHER MD, REX R, 1133 COLLEGE, 66502
 776-1400 3005600251
 34 M 3005 68 08G

FREEMAN MD, FRED A, 1133 COLLEGE, 66502
 537-8710 1902690383
 42 M 1902 70 U

GARNER MD, JAMES D, 1133 COLLEGE, 66502
 537-4940 2834710318
 43 M 2834 76 IM

HANCOCK MD, DANIEL E, 1133 COLLEGE PO BOX 128, 66502
 539-5363 2803710239
 45 M 2803 78 PATH

HAUN MD, RUOY T, 1133 COLLEGE 8LOG O, 66502
 537-8611 1902780781
 49 M 1902 82 08G

HEASTY MD, ROBERT G, 3120 HERITAGE LN #169, 66502
 3519380411
 11 M 3519 46 00

HENNING JR MD, HAROLD J, 1133 COLLEGE, 66502
 537-1414 1902820732
 55 M 1902 08G

HINKIN MD, DOUGLAS P, 2900 AMHERST, 66502
 776-9761 1902780803
 53 M 1902 84 FP

JONES MD, WILLIAM T, 2600 ANDERSON, 66502
 537-4200 1902752257
 50 M 1902 85 ORS

JUBELT MD, HILBERT P, 2010 MEADOWLARK RD, 66502
 1611431313
 19 M 1611 49 00

KALOOR MO,RICHARD H, 1133 COLLEGE AVE, 66502
539-5363 2401661339
40 M 2401 73 PATH

KIRK MO,THOMAS E, 1133 COLLEGE, 66502
776-3451 3005710463
44 M 3005 76 OPH

KLINGLER JR MO,EUGENE A, 1133 COLLEGE AVE, 66502
539-5341 1902620466
35 M 1902 63 GS

KLOBASA MO,CHARLES L, 200 SOUTHWIND PL #202, 66502
539-5337 2803750494
49 M 2803 80 CHP

LOWE MO,STANLEY W, 1133 COLLEGE, 66502
776-3451 1902590516
32 M 1902 63 OPH

LYONS JR MO,FRANK C, 1133 COLLEGE, 66502
539-7641 3840700916
44 M 3840 74 OR

MCNEIL MO,ELBERT O, 2020 HUNTING AVE, 66502
702480337
22 M 702 49 00

MEEK MO,PALMER F, 1133 COLLEGE, 66502
537-2651 1902710716
45 M 1902 71 IM

MOSIER MO,STEVEN J, 2900 AMHERST, 66502
776-9761 1902680701
49 M 1902 75 FP

MOWRY MO,GERALO L, 1441 ANDERSON, 66502
776-4200 1902530599
26 M 1902 53 OBG

OLNEY MO,ROBERT O, 1133 COLLEGE, 66502
539-7555 3005510553
27 M 3005 59 GS

PETERSON O O,PEGGY S, 1133 COLLEGE BOX 128, 66502
539-5363
52 F 2878 80 PATH

PETERSON JR MO,JACK T, 1133 COLLEGE AVE BLOG A, 66502
539-3504
00 M EENT

PETERSON MO,JACK T, 1133 COLLEGE PO BOX 128, 66502
539-5363 1902500525
25 M 1902 50 PATH

PHILIPP MO,JOSEPH THEODORE, 1133 COLLEGE BLOG O, 66502
537-7373 1902710881
45 M 1902 72 OPH

ROSE MO,GRAHAM C, 1133 COLLEGE, 66502
537-9030 4706701031
46 M 4706 74 PO

SHEFFIELD MO,MICHAEL A, 1133 COLLEGE, 66502
539-7641 1902821721
55 M 1902 86 OR

SHIELDS MO,THOMAS M, 1133 COLLEGE AVE, 66502
539-5341 1902742537
49 M 1902 77 GPVS

SMITH MO,RACHEL, 1133 COLLEGE AVE, 66502
537-9030 1902851590
00 F 1902 PO

STONE MD,G REX, 360 WILDCAT CREEK RD, 66502
1902540926
29 M 1902 54 00

TAYLOR MO,BARBARA O, 1133 COLLEGE, 66502
357-4940 1902751901
50 F 1902 79 IM

TIEMANN MO,WILLIAM H, 1133 COLLEGE, 66502
537-4940 3005670747
42 M 3005 73 FP

VOLKMANN II MO,HARLEY W, 1133 COLLEGE, 66502
539-7641 1902721173
47 M 1902 73 R

WETZEL MO,MARK, 1133 COLLEGE AVE, 66502
537-2651 1902861927
59 M 1902 IM

WIGGLESWORTH MO,ANNE, 1133 COLLEGE AVE BLOG A, 66502
539-4738 1902753016
40 F 1902 79 OBG

MANKATO — 913
(Republic County Medical Society)

KIMBALL MO,RICHARD R, 102 S CENTER, 66956
378-3511 1001720585
45 M 1001 73 FP

MARION — 316
(Marion County Medical Society)

HOOSON MO,DOON W, 537 S FREEBORN, 66861
382-3722 1902790914
53 M 1902 FP

MARYSVILLE — 913
(Northeast Kansas Medical Society)

ARGO MO,DOONALO, 808 N 19TH, 66508
562-2303 3005640058
36 M 3005 65 FP

LAWS MO,LEWIS R, 808 N 19TH, 66508
562-2303 1902540535
25 M 1902 54 FP

RYAN MO,JOHN M, 1902 MAY, 66508
562-2303 1902811164
47 M 1902 FP

MCLOUTH — 913
(Shawnee County Medical Society)

PALAGANAS-TOSCO MO,AMANO C, 313 S UNION, 66054
796-6116 74801702132
45 F 74801 86 FP

SNOOK MO,ROBERT RUFUS, , 66054
1902420653
11 M 1902 42 00

MCPHERSON — 316
(McPherson County Medical Society)

BILLINGS MO,THOMAS, 400 W 4TH, 67460
241-5500 1902660107
39 M 1902 67 FP

BRANOSTEO MO,ERNEST C, 400 W 4TH, 67460
241-1654 1606440185
18 M 1606 47 OBG

BULLER MO,DAVIO L, 400 W 4TH, 67460
241-7400 1902850232
58 M 1902 FP

CABRERA MO,ALBERT, 915 N WALNUT, 67460
241-4079 74801553021
30 M 74801 80 GS

CLAASSEN MO,SAMUEL O, 400 W FOURTH, 67460
241-7033 1902780323
53 M 1902 79 IM

COLLIER MO,WILLIAM J, 400 W 4TH, 67460
241-1766 3605480097
25 M 3605 59 GS

FERREE MD,RICHARD ALLAN, 400 W FOURTH, 67460
241-7400 3006760189
51 M 3006 78 FP

FIELDS MD,GALEN W, 333 C - S LAKESIOE DR, 67460
1902490228
15 M 1902 49 00

JOHNSON MD,J RICHARD, 400 W 4TH, 67460
1902550603
28 M 1902 55 00

PIERSON MD,WEIR, 1000 HOSPITAL DR, 67460
241-1445 1902441197
17 M 1902 44 FP

PRICE MD,VAUGHAN C, PO BOX 451, 67460
4706290376
05 M 4706 32 GS

THOMAS MD,GREGORY MCQUEEN, 400 W FOURTH, 67460
241-7400 1902731161
47 M 1902 79 FP

MEADE — 316 (Iroquois County Medical Society)

FELDMAYER MO,SEELEY T, PO BOX 1030, 67864
873-5432 74811800027
46 M 74811 81 GP

HILL MO,RICHARD H, BOX 709, 67864
1902440697
18 M 1902 44 00

MEDICINE LODGE — 316 (Ninnescah Medical Society)

MEADOR O O,RICHARD W, 710 N WALNUT, 67104
886-5949
00 M

STUCKY MD,DEAN E, 901 N WALNUT, 67104
886-5653 1902600848
33 M 1902 61 FP

MINNEAPOLIS — 913 (Saline County Medical Society)

BARKER MO,STEVEN E, 311 N MILL, 67467
392-2144 1902760098
51 M 1902 77 FP

WEDEL MD,KENNETH D, 311 N MILL, 67467
392-2144 1902600937
32 M 1902 61 FP

WEDEL MD,KERMIT G, 311 N MILL, 67467
392-2144 1902600945
32 M 1902 61 FP

MINNEOLA — 316 (Iroquois County Medical Society)

STEPHENS D O,G MARCUS, 222 MAIN, 67865
885-4202 2878840189
57 M 2878 85 FP

STEPHENS MD,CHARLES, BOX 97, 67865
885-4202 2803580319
33 M 2803 60 FP

MOUNDRIDGE — 316 (Harvey County Medical Society)

KAUFMAN MD,WILLARD E, PO BOX 640, 67107
345-6322 1902530459
28 M 1902 53 FP

LOGANBILL MD,VARDEN J, PO BOX 640, 67107
345-6322 1902540560
26 M 1902 54 FP

MULVANE — 316 (Sedgwick County Medical Society)

CARRO MO,ANTONIO L, 102 E MAIN, 67110
777-0101 1902850305
57 M 1902 87 FP

COBB MO,LESLIE H, RR 1 BOX 196, 67110
4804470129
17 M 4804 49 00

MCKERRACHER MO,ROBERT D, 10 LAKE DR, 67110
3901550742
27 M 3901 56 00

NEODESHA — 316 (Southeast Kansas Medical Society)

BARRETT MO,BRADLEY H, PO BOX 315, 66757
325-3055 1902830177
57 M 1902 FP

CHRONISTER MO,BERT, PO BOX 118 806 MAIN, 66757
325-2622 1902640122
38 M 1902 65 FP

MOORHEAD JR MD,F ALLEN, 709 MAIN BOX 180, 66757
325-2200 1902650624
39 M 1902 66 FP

NESS CITY — 913 (Central Kansas Medical Society)

DOAK MD,BASCOM P, 412 N TOPEKA, 67560
798-2233 3901730350
36 M 3901 89 FP

IMSEIS MO,MIKHAIL Y, 722 E LOCUST, 67560
798-2203 91502750068
50 M 33004 GP

NEWTON — 316 (Harvey County Medical Society)

ALLEN MD,FRANCES A, 1112 BOYD, 67114
1902430012
15 F 1902 43 00

BATES MO,MICHAEL N, 215 S PINE STE 302, 67114
283-4153 1902751587
50 M 1902 77 OBG

BECK MD,WILLIAM R, 203 E BROADWAY, 67114
283-2800 1902830223
55 M 1902 87 OPH

BOGNER MO,PAUL F, 203 E BROADWAY, 67114
283-2800 1902770158
52 M 1902 80 GS

CARPER MD,IVAN H, 203 E BROADWAY, 67114
283-2800 1902590125
28 M 1902 60 GS

CARPER MD,DWEN E, #5 SYCAMDRE CT, 67114
 283-8522 190264D106
 37 M 19D2 65 FP

CLAASSEN MD,MILTDN A, 2D1 S PINE ST, 67114
 283-360D 190258D189
 32 M 19D2 59 DRS

CRAIG MD,CHARLES C, AXTELL CL 2D3 E 8RDADWAY, 67114
 283-28DD 1902710252
 45 M 19D2 72 DRS

DAVIS MD,KEVIN B, 2D3 E 8RDADWAY, 67114
 283-28DD 481281D443
 53 M 4812 DBG

DYCK MD,GEDRGE, 19D1 EAST FIRST ST, 67114
 283-24DD 620164D154
 37 M 62D1 73 P

ENNS MD,EUGENE K, 6 INDIAN LN, 67114
 19D24DD199
 15 M 1902 40 DD

FENT MD,LEE S, 7D1 E 5TH, 67114
 8283443D617
 14 M 2834 44 DD

FRIESEN MD,DRLANDD J, PD 8DX 97, 67117
 19D256D391
 27 M 1902 56 DD

FRUECHTING MD,LYNNE A, 2D1 S PINE, 67114
 283-36DD 190285D933
 59 F 1902 88 PD

GLDVER MD,RICHARD M, AXTELL CL 2D3 E 8RDADWAY, 67114
 283-28DD 19D2530297
 21 M 1902 53 FP

GRISWDLD MD,DALE G, AXTELL CL 2D3 E 8RDADWAY, 67114
 283-28DD 19D253D327
 27 M 19D2 53 IM

HALE MD,WILLIAM R, BDX 467, 67114
 283-24DD 19D277D581
 52 M 1902 79 P

HAMM MD,GLENN, 201 S PINE, 67114
 283-36DD 1902822D42
 54 M 19D2 87 PD

HAMM MD,ORVAL L, 201 S PINE, 67114
 755-2349
 23 M 1902 49 FP

HARMS MD,EDWIN M, 3001 IVY DR #1125, 67117
 39D134D179
 D6 M 39D1 36 OD

HEINRICHS MD,DANIEL J, 19D1 E 1ST ST, 67114
 283-240D 4D0256D289
 29 M 4D02 89 P

ISAAC MD,CHARLES A, 203 E 8RDADWAY, 67114
 283-28DD 1902490341
 25 M 19D2 49 U

JANTZ MD,JONATHAN W, 201 S PINE, 67114
 283-36DD
 55 M 28D2 89 PD

KLIEWER MD,VERNDN L, PO 80X 467, 67114
 283-24DD 16D657D585
 31 M 1606 58 PA

KUMAR MD,SURINDER, 201 S PINE, 67114
 283-3600 4951269D016
 46 M 19D2 78 DBG

LINDHOLM MD,GERALD R, AXTELL CL 2D3 E 8RDADWAY, 67114
 283-28DD 190276D772
 51 M 19D2 78 FP

MCCOWN MD,ROBERT B, 19D1 E 1ST ST, 67114
 262-4739 284677D235
 52 M 2846 87 FP

MOORE MD,JAMES E, 19D1 E 1ST, 67114
 283-240D 19D274D48D
 48 M 19D2 75 P

MDRGAN MD,SCOTT, 2D1 S PINE, 67114
 883-36DD 21D5791081
 D0 M IM

NACHTIGALL MD,ANDREW, 2D1 S PINE, 67114
 283-36DD 19D259D621
 28 M 19D2 64 PD

DLSDN MD,ERWIN T, NO 3 INDIAN LN, 67114
 19D247D448
 19 M 19D2 47 DO

PRENTISS MD,HARDLD, 13D5 TERRACE DR, 67114
 283-9433 172D62D975
 36 M 172D 77 R

QAMAR MD,YUSUF, 2D3 E 8RDADWAY, 67114
 283-2800 7D4D961DD46
 38 M 7D4D9 70 IM

SCHMIDT MD,HER8ERT R, 413 SE 1DTH ST., 67114
 19D234D463
 D3 M 19D2 34 DD

SILLS MD,CHARLES T, 1631 HILLCREST, 67114
 19D2370524
 D9 M 19D2 37 DD

SIMMONS MD,RD8ERT EARLE, 2D9 S PINE, 67114
 283-5D4D 1902742014
 49 M 19D2 76 IM

STEVENS MD,RDNALD, 2D1 S PINE, 67114
 883-36DD 64914777249
 49 M 64914 87 FP

TANDOC JR MD,VALENTIN T, BETHEL CL 2D1 S PINE, 67114
 283-36DD 7481162DD61
 39 M 748D9 74 U

TURNER MD,RDBERT N, 2D1 S PINE, 67114
 283-3600 1902871761
 59 M 19D2 88 FP

VDGT MD,VERNON W, 323 E SECDND, 67114
 3005530864
 22 M 3005 55 00

WHEELER MD,DWIGHT E, 2D1 S PINE, 67114
 283-36DD 2012760941
 5D M 2D12 79 IM

WIENS MD,J WENDELL, 201 S PINE, 67114
 283-36DD 19D2590982
 32 M 19D2 6D GS

WILLIAMS MD,MICHAEL K, 203 E 8ROADWAY, 67114
 283-2800 1902871868
 6D M 19D2 91 FP

ZAYLDR D O,CHARLES L, 19D1 E FIRST, 67114
 283-240D
 52 M 2878 GS

NORTON — 913 (Northwest Kansas Medical Society)

CODPER MD,ARTHUR E, 307 W WIL8ERFORCE, 67654
 161135033D
 D8 M 1611 36 DD

HARTLEY MD,ROY W, 711 N NORTDN, 67654
 877-33D5 190263D3D5
 37 M 19D2 64 GP

HARTMAN MD,RDGER L, 711 N NDRTDN, 67654
 877-33D5 19D2610339
 35 M 19D2 65 FP

LDNG MD,RD8ERT C, PO BOX 29, 67654
 19D253D556
 27 M 19D2 53 DD

NORTONVILLE — 913 (Atchison County Medical Society)

MADISDN MD,WILLARD A, BDX 68, 66D60
 19D2510466
 2D M 19D2 51 00

OAKLEY — 913
(Northwest Kansas Medical Society)

OHMART MO, RICHARD V, PO BOX 756, 67748
672-3262 1902620636
36 M 1902 63 FP

OLATHE — 913
(Johnson County Medical Society)

ANDERSON MO, CRAIG A, 225 W 151ST ST STE 101, 66061
782-8577 1902850020
58 M 1902 GS

ARNSPIGER II MO, RICHARD C, 225 W 151ST ST STE 101, 66061
782-8577 1902820031
56 M 1902 GPVS

BROOKS MO, CHARLES L, 20375 W 151ST ST #170, 66061
829-2829 1902790272
54 M 1902 85 GE

BYRNES MO, JOHN J, 225 W 151ST STE 406, 66061
791-4220 2846840110
60 M 2846 87 AN

COPENING MO, TELL B, 225 W 151ST STE 105, 66061
782-7818 1902690219
43 M 1902 70 FP

OELPHIA MO, ROBERT E, 13045 S MUR-LEN RD, 66062
782-1610 1902832196
24 M 1902 56 FP

FEEHAN MO, JOHN M, 405 S CLAIRBORNE PO BOX 910, 66061
782-3322 1902840571
57 M 1902 87 FP

FORTUNE MO, CEORIC B, PO BOX 910, 66061
782-3322 1902660298
40 M 1902 67 FP

FOWLER MO, DENNIS L, 225 W 151ST STE 101, 66062
782-8577 1902731357
48 M 1902 GS

GAUGHAN MO, REBECCA N, 13025 S MUR-LEN #200, 66062
764-2737 3006820343
55 F 3006 87 OTO

HALVORSON MO, HOWARD C, 225 W 151ST STE 201, 66061
782-2020 5404660260
41 M 5404 75 U

HERRON MO, KRISTINE G, 225 W 151ST STE 104, 66061
474-9353 1902840792
57 F 1902 NEP

HUOSON MO, ROBERT P, 12925 FRONTIER RD, 66061
588-7040 1902520313
26 M 1902 52 IM

JACKSON MO, THOMAS M, 225 W 151ST STE 350, 66061
764-6996 1902840946
56 M 1902 91 GS

JENSEN MO, THOMAS M, 225 W 151ST STE 106, 66061
782-1148 3005730464
47 M 3005 75 ORS

KENNEY MO, FREDERICK R, 225 W 151ST STE 101, 66061
782-8577 1902680493
42 M 1902 GS

KLEINSASSER MO, WARREN L, 14901 W 117TH ST, 66061
764-5555
37 M 2604 88 FP

KLUMP MO, RICHARD, 225 W 151ST ST #201, 66061
782-2020
58 M 3843 U

LAIRO MO, OALE O, 151 W 151ST STE 100, 66061
782-3631 1902680540
42 M 1902 69 OPH

MACFARLANE MO, DOUGLAS B, 225 W 151ST STE 200, 66061
782-3073 1902800715
54 M 1902 81 OBG

MARINE MO, CLIFFORD S, 22500 W 151ST #250, 66061
764-6262 1902841195
57 M 1902 85 OBG

MATTHEW MO, WILLIAM L, 405 S CLAIRBORNE, 66061
782-3322 1902560706
29 M 1902 56 FP

MCCANN MO, WILLIAM E, 1006 LENNOX DR, 66062
3901480337
22 M 3901 53 00

MENOLICK MO, R MICHAEL, 225 W 151ST STE 106, 66061
782-1148 1902700788
44 M 1902 71 ORS

MORGAN II MO, DAVIO LLOYD, 225 W 151ST STE 301, 66061
782-8300 2846750161
49 M 2820 75 IM

NOTTINGHAM MO, ROBERT M, 13045 S MUR-LEN, 66062
782-1610
49 M 1902 FP

RHOADS MO, ANNE C, 20375 W 151ST ST #350, 66061
764-6996 1902831521
57 F 1902 85 GS

ROMONOO MO, STEVEN A, 225 W 151ST STE 406, 66061
791-4220 1902730989
47 M 1902 75 AN

RUHLEN MO, JAMES L, 225 W 151ST STE 301, 66061
782-8300 1902720959
46 M 1902 73 IM

RUHLEN MO, THOMAS F, 215 W 151ST, 66061
791-4362 1902761141
51 M 1902 PATH

SCHAPER MO, DANIEL C, 225 W 151ST STE 106, 66061
782-1148 1902810681
54 M 1902 87 ORS

SHEFFER MD, KEITH O, 225 W 151ST STE 106, 66061
782-1148 1720671651
37 M 1720 74 ORS

SNIDER MD, BRUCE B, 22500 W 151ST #250, 66061
764-6262 1902861633
59 M 1902 89 OBG

SNYDER MD, RICHARD H, 225 W 151ST STE 406, 66061
791-4220 1902731080
45 M 1902 75 AN

STANOLEE MD, TIM E, 225 W 151ST STE 406, 66061
791-4220 1902821801
56 M 1902 85 AN

WARNER MD, RICHARD B, 225 W 151ST ST #206, 66061
782-2593 1902721203
45 M 1902 85 P

WETZEL MD, JAMES L, 225 W 151ST STE 301, 66061
782-8300 1803811551
52 M 1803 IM

WOODS MO, S OWIGHT, 20375 W 151ST ST #350, 66061
764-6996 1902551219
30 M 1902 55 GS

ZEILER MD, STEVEN B, 225 W 151ST, 66061
782-8300
57 M 1103 83 IM

ZIMMERMAN MO, BRUCE E, 225 W 151ST STE 203, 66061
782-3377 4812781729
49 M 4812 79 OTO

ONAGA — 913
(Pottawatomie County Medical Society)

BURT MO, RONALD J, 114 W 8TH, 66521
889-4241 1902840326
47 M 1902 86 FP

ENGELKEN MO, SUSAN F, 120 W 8TH, 66521
889-4271 3401790127
49 F 3401 84 GP

TARVIN MD,RANDY J, 114 W 8TH, 66521
889-4241
59 M 1902 89 FP

WALSH MD,THOMAS E, ONAGA CL 100 W 8TH, 66521
889-4241 1902741212
48 M 1902 75 FP

OSAGE CITY — 913 (Flint Hills Medical Society)

ADAMS MD,DWIGHT, 608 HOLLIDAY, 66523
528-3161 1902560013
00 M 1902 56 GP

OSAWATOMIE — 913 (Miami County Medical Society)

APPENFELLER MD,WILLIAM O, 524 BROWN AVE, 66064
755-3166 1902530033
25 M 1902 53 FP

OSWEGO — 316 (Labette County Medical Society)

BURGESS MD,ARTHUR P, PO BOX 126, 67356
1902520101
19 M 1902 52 00

OTTAWA — 913 (Franklin County Medical Society)

GOLLIER II MD,ROBERT A, 1418 S MAIN ST #S-5, 66067
242-1620 1902660344
40 M 1902 67 FP

HADLEY MD,DELMONT C, 1320 S ASH, 66067
242-3891 1902640335
35 M 1902 65 FP

HENNING MD,CALVIN W, PO BOX 2, 66067
1902350167
05 M 1902 35 00

RANSOM,WILLARD B, 1418 S MAIN ST #S-5, 66067
242-1620 1902782300
49 M 1902 79 FP

REYES JR MD,FRANCISCO A, 1320 S ASH, 66067
242-5312 74801610734
38 M 74801 74 GS

REYNOSO MD,LANCE A, 1418 S MAIN ST #S-5, 66067
242-1620 1902861404
00 M 1902 FP

SPEER MD,LOUIS N, PO BOX D, 66067
242-1257 1606411177
14 M 1606 41 FP

SPRATT MD,DENNIS P, 1418 S MAIN ST #S-5, 66067
242-1620 1902841705
00 M 1902 FP

OVERBROOK — 913 (Flint Hills Medical Society)

RUBLE JR MD,JAMES L, OVERBROOK COMM CLINIC, 66524
665-2205 1902530785
26 M 1902 53 FP

PAOLA — 913 (Miami County Medical Society)

BANKS MD,ROBERT E, PO BOX 298, 66071
294-2305 1902550085
29 M 1902 55 FP

HOLSCHER MD,MARK R, 1313 BAPTISTA, 66701
294-2000 1902850798
55 M 1902 FP

ROWLETT MD,JACK G, PO DRAWER A, 66071
294-2356 1902520551
21 M 1902 52 FP

STANLEY MD,REX C, PO DRAWER A, 66071
294-2056 1902520631
24 M 1902 52 GS

PARSONS — 316 (Labette County Medical Society)

AVES MD,AGNES, 1509 MAIN, 67357
421-0600 74801592353
38 F 74801 72 IM

AVES MD,RENATO B, 1509 MAIN, 67357
421-0600 74801592264
35 M 74801 72 GS

CAREY MD,LARRY J, 400 KATY, 67357
421-2700 1902770271
51 M 1902 78 FP

CHOI MD,PHILIP S, 2601 GABRIEL, 67357
421-6550
26 M 58302 81 GP

CORNELL MD,EARL G, 1509 MAIN, 67357
421-0600 1902790434
54 M 1902 83 FP

DAIZ MD,ANTONIO S, PO BOX 935, 67357
421-4880 74810630918
37 M 74810 80 DR

DILLON MD,WILLIAM L, LABETTE CO MED CL BOX H, 67357
421-0881 1902710295
45 M 1902 73 ORS

KISHORE MD,SHEELA, 2907 JOHNSON RD, 67357
421-4251 49511660041
43 F 49511 74 AN

LAVA MD,CHIRUND, PO BOX 290, 67357
421-6210 89102630484
40 M 89102 76 GS

MENON MD,REMA, PARSONS ST HOSP, 67357
421-6550 49531730126
47 M 49531 78 GP

MILLER MD,DEAN M, 203 CRESTVIEW, 67357
1902480311
22 M 1902 48 00

MILLER MD,STEPHEN FRANCIS, 1509 MAIN, 67357
421-0600 1902700800
45 M 1902 72 GS

MOSIER MD,KEVIN M, BOX H STE ONE, 67357
421-0881 1902831343
57 M 1902 88 ORS

PAI MD,RADHA V, PO BOX 1057, 67357
421-0080 49553700077
45 F 6701 78 AN

PAI MD,VARADARAJ S, PO BOX 1057, 67357
421-0080 49521650205
42 M 6701 78 U

PARANJOTHI MD,SUBRAMONIAM P, 1509 MAIN, 67357
421-0600 49531650131
39 M 49531 74 IM

PAULS MD,DANIEL N, LABETTE CO MED CTR HWY 59 S, 67357
421-1431 1902710856
45 M 1902 72 IM

ROTHSTEIN MO, TERRY B, PO BOX B, 67357
421-5900 1606691072
43 M 1606 76 OPH

SATYA-MURTI MO, SATYA, LABETTE CO MEO CL HWY 59 SOUTH, 67357
421-8884 49516650078
00 M 49516 N

SHARMA MO, ARUN L, 1509 MAIN, 67357
421-0600 49607690056
46 F 49503 77 FP

TANANUNKUL MO, URAIWAN, PO BOX 256, 67357
421-2460 89101750052
51 M 89101 PO

TANG MO, CHANTRA, PO BOX 1054, 67357
421-2460 89102710321
47 F 89104 82 PO

TANG MO, SAROHO, PO BOX 1054, 67357
421-2460 89102690550
43 M 89102 76 OBG

VERMA MO, ASHA, 400 KATY, 67357
421-2700 49530630136
37 F 49530 76 PO

WELCH MO, JAMES R, 400 KATY, 67357
421-2424
52 M 3901 PATH

MENOIOLA MO, AMBRISIO P, MT CARMEL MEO CTR, 66762
231-6100 74810671428
39 M 74810 82 EM

MILLER MO, EARL E, 1803 S COLLEGE TERR, 66762
1902370427
13 M 1902 37 00

MULLER MO, SAMUEL B, 611 W QUINCY, 66762
1902340391
05 M 1902 34 00

OOGERS MO, ROONEY K, 909 CENTENNIAL, 66762
231-4300 1902741697
00 M 1902 75 IM

PAPP JR MD, S OEAN, R 5 BOX 293, 66762
231-7650 1902720908
46 M 1902 80 OR

PARSI MO, MANUTCHEHR, 909 CENTENNIAL, 66762
231-3770 51701640393
38 M 51701 74 GYN

POGSON MO, GEORGE W, RR 3 BOX 23, 66762
1902470464
24 M 1902 47 00

RAMIREZ MD, AUGUSTO H, 909 CENTENNIAL, 66762
231-6280 26407580019
32 M 26407 71 GS

RAMIREZ MO, IRENE P, 909 CENTENNIAL, 66762
231-6280 74801671601
43 F 74801 71 PO

SCHLEMMER MO, ROGER B, 1003 S BROADWAY, 66762
231-6380 1902680884
37 M 1902 68 OPH

SEARLE MO, ROBERT E, 101 N PINE ST, 66762
231-7164
37 M 5101 86 OPH

SEGLIE MO, F RONALD, #3 MEO CENTER CIR, 66762
231-6280 1902690944
43 M 1902 70 FP

TAWIL MO, ELIAS A018, 2701 S ROUSE, 66762
231-0850 91502760012
52 M 33004 83 U

TWEET MO, FREDRICK A, RR 5 BOX 196, 66762
231-6100 1602660652
39 M 1602 68 PATH

WHITE O O, JOHN P, CENTENNIAL & ROUSE, 66762
232-2270
43 M 1875 76 P

YAGHMOUR MO, TALAAT E, 2701 S ROUSE, 66762
231-0850 33004640018
40 M 33002 72 U

ZABEL MO, KENNETH P, 909 CENTENNIAL, 66762
231-1650 1902651027
37 M 1902 66 IM

PITTSBURG — 316 (Crawford-Cherokee County Medical Society)

ARMSTRONG MO, HAROLD J, 207-208 PROFESSIONAL BUILDING, 6676
232-2600 1902680035
40 M 1902 69 ORS

BENA MO, JAMES, 405 WEBSTER, 66762
3005360055
12 M 3005 38 00

BERKEY MO, VERNON A, NATL BANK BLDG, 66762
231-7650 1902430080
18 M 1902 43 R

BIERLEIN MO, KENNETH J, 812 S CATALPA, 66762
1606330169
06 M 1606 33 00

COOMER MO, TYLER E, 315 NATL BANK BLDG, 66762
231-7730 2101590189
30 M 2101 65 GS

ERICKSON MO, CLARENCE W, 812 ELMWOOD LN, 66762
231-7400 1902330140
06 M 1902 33 IM

GOMETZ MO, MOESTO S, PO BOX 1746, 66762
231-2490 72601660025
35 M 72601 71 PO

GRIMALDI MO, GARY A, PITTSBURG ST U STU HLTH CNTR, 66762
223-3100 1902741964
49 M 1902 76 OBG

HOLSINGER MO, DONALD M, 1015 MT CARMEL PL, 66762
231-5900 1902640394
38 M 1902 65 IM

HUESNER MO, ROBERT STEPHAN, 1015 E MT CARMEL PL, 66762
231-6160 1606670474
42 M 1606 78 GPVS

HUERTER MO, DAVIO F, 909 CENTENNIAL, 66762
231-1650 1902720614
46 M 1902 75 IM

LANCE MO, RAYMOND W, 604 SYCAMORE LANE, 66762
1902470359
22 M 1902 47 00

LEFFLER MO, PAUL B, 309 WINWOOD, 66762
1902400318
02 M 1902 40 00

MCOANIEL MO, R JAMES, PO BOX 1746, 66762
231-2490 1902821178
50 M 1902 85 PO

PLAINVILLE — 913 (Central Kansas Medical Society)

KELLY O O, MARK A, 300 S COLORADO, 66763
434-4602
50 M 3979 90 GP

PEDERSON MO, ARNOLD M, 300 COLORADO, 66763
434-4609 1902510601
22 M 1902 51 FP

PLEASANTON — 913 (Anderson County Medical Society)

JUSTUS MO, WILLIAM J, PO BOX 407, 66075
352-6134 1902550611
29 M 1902 55 FP

PRATT — 316
(Ninnescah Medical Society)

AMBLER MO,CARL D, PO BOX 364, 67124
672-6476 1902570019
31 M 1902 57 R

BARKER MO,PATRICK N, PO BOX 869, 67124
672-7411 1902710040
45 M 1902 72 GS

BLACK MO,CYRIL V, RR 2, 67124
48D2300021
05 M 48D2 31 00

BLOOM MO,L THEIL, 1408 E MAPLE, 67124
672-9297 1902570051
32 M 1902 57 R

DILLDN MD,STEVEN C, 420 COUNTRY CLUB RD, 67124
672-7417 19D2780510
53 M 1902 82 IM

FREEMAN MO,F GILES, 310 E 2ND, 67124
672-5555 1902440557
18 M 19D2 44 FP

FRIESEN MD,RICK W, 420 COUNTRY CLUB RD, 67124
672-7422 1902860572
59 M 1902 FP

PAULY MD,TIMOTHY R, 420 COUNTRY CLUB RD, 67124
672-7422 19D2821488
56 M 1902 85 FP

RDSN MD,CARL H, PO BOX 8564, 67124
672-9454 4812721114
46 M 4812 84 U

SUITER MD,DANIEL JAY, 42D COUNTRY CLUB RD, 67124
672-7411 1902711097
44 M 1902 74 GE

PROTECTION — 316
(Iroquois County Medical Society)

GLENN MO,LYLE G, 146 BROADWAY BOX 447, 67127
1606400418
12 M 1606 40 00

QUINTER — 913
(Northwest Kansas Medical Society)

HIESTERMAN MD,HERMAN W, 116 E 4TH, 67752
754-3333 1902510318
23 M 1902 51 OD

RANSOM — 913
(Central Kansas Medical Society)

MCLAIN MO,KENNETH, BOX 247, 67572
731-2295 190246D388
21 M 1902 46 FP

RUSSELL — 913
(Central Kansas Medical Society)

MERKEL MO,EARL D, SHIELDS BLOC 326 N MAIN, 67665
483-2178 1902570604
32 M 1902 57 FP

STARKEY MO,JERALO L, 326 MAIN, 67665
483-2178 19D2561044
30 M 1902 56 FP

SWANN MD,CLAIR L, 112 W SIXTH, 67665
483-4212 1902390541
13 M 1902 39 IM

WHITE MD,FAGAN N, 356 W 5TH, 67665
70236D447
11 M 702 37 00

SABETHA — 913
(Northeast Kansas Medical Society)

KENNALLY MD,KEVIN P, PO BOX 247, 66534
284-2141 1902780927
53 M 1902 81 FP

WENGER MO,GREGG D, PO BOX 247, 66534
284-2141 1902781958
00 M 1902 81 PD

YULICH MD,JOHN O, PO BOX 227, 66534
284-2125 1902591016
33 M 1902 61 FP

SALINA — 913
(Saline County Medical Society)

ABBOTT D O, GREGDRY A, PO BOX 1757, 67402
825-7251 2878820072
55 M 2878 88 FP

ALSOP MD,WILLIAM R, PO BOX 260, 67402
827-7261 190277D042
52 M 78 GE

ANOERSDN MO,JOOY, PO BOX 260, 67402
827-7261 1902590010
32 F 1902 64 IM

BAXTER MO,W REESE, PO BOX 1847, 674D2
825-8221 1902730083
47 M 1902 74 FP

BELL MO,MARK G, 909 E WAYNE, 67401
823-7225 1902751595
50 M 1902 77 ENT

BLOMQUIST MD,GLENDA L H, 1508 E IRON, 67401
827-1193 1902852031
56 F 1902 86 P

BOSSEMAYER II MD,CHARLES H, 617 E ELM PO BOX 1847, 67401
825-8221 190278D200
49 M 1902 84 FP

BROWN MO,ROBERT WAYNE, 910 MARYMOUNT RD, 67401
1902550174
23 M 1902 55 00

BRUNGAROT MD,BERNARD A, 400 E BELOIT, 67401
3006460045
21 M 3DD6 46 OD

BURNETT D D,LARRY E, 1101 E REPUBLIC, 67401
823-7470 287984D425
58 M 2879 85 FP

BYERS MD,JDNEEL, 833 ELMHURST, 67401
823-8140 1902781991
53 F 1902 79 D

CANNAOAY MO,JOHN J, PO BOX 2327, 67402
827-3771 3901840309
56 M 39D1 85 R

CATHCART-RAKE MO,WILLIAM F, BOX 260, 67402
827-026D 1902740895
48 M 1902 75 IM

CLARK MO,OAVID H, PO BOX 1847, 67402
825-8221 190262D091
36 M 1902 63 FP

CONNOR MD,BRIAN, 1518 B EAST IRON, 67401
825-2020 1902720231
46 M 1902 73 OPH

COOPER MO, JAMES L, PO BOX 2027, 67402
823-7201 1902820376
56 M 1902 83 PATH

COSSETTE MO, JERROLD E, 909 E WAYNE, 67401
823-7225 1902751781
46 M 1902 76 ENT

COVERT MO, THOMAS J, 737 E CRAWFORD, 67401
827-7261 1902710244
00 M 1902 72 PO

CULTRON MO, FRANK T, 837 O FAIROALE RD, 67401
1643380214
10 M 1643 47 00

O'SOUZA MO, BISMARCK C, PO BOX 2327, 67402
827-9526 49501680370
45 M 49501 78 R

DEBIASSE MO, OEBRA J, 135 E CLAFLIN, 67401
827-9631 1902870454
52 F 1902 90 PD

DENNIS MO, OAVIO T, 737 E CRAWFORD PO BOX 260, 67401
827-7261 1902780501
53 M 1902 78 IM

DETURK MO, OWAYNE L, PO BOX 2327, 67401
827-9526 3005830272
51 M 3005 84 R

DRAEMEL MO, H RICHARD, 2203 EDGEHILL RD, 67401
827-0307 1902530246
18 M 1902 53 OT0

OREHER MO, HENRY S, PO BOX 260, 67402
827-7261 1902430284
18 M 1902 43 IM

EATON MO, GLEN E, 4353 E NORTH ST, 67401
1902540268
28 M 1902 54 00

EATON MO, LESLIE F, RR 1 BOX 346, 67401
1902320152
06 M 1902 34 00

ELLISON MO, PAUL O, 1499 E IRON, 67401
825-7271 2105600421
35 M 2105 67 OPH

FEIGHNY MO, ROBERT E, 2437 VILLAGE, 67401
1902510181
20 M 1902 51 00

FERGUSON MO, ELAINE L, PO BOX 1847, 67402
825-5717 2878830299
00 F 2878 IM

FRANCIS MO, ANTHONY E, PO BOX 2478, 67401
823-1025 1902770484
54 M 1902 82 ORS

FREEMAN MO, RAYMOND S, 1901 E IRON, 67402
702500192
20 M 702 59 00

FULLEN MO, JERYL G, 523 S SANTA FE, 67401
823-7213 401680268
43 M 401 76 ORS

GANS MO, FREDERICK A, 950 S ELEVENTH, 67401
2834460354
22 M 2834 51 00

GARLOW MO, WILLIAM B, PO BOX 2327, 67402
827-9526 1902820554
55 M 1902 87 R

GRANT MO, MICHAEL O, 1001 S OHIO, 67401
827-6453 1902790752
51 M 1902 82 FP

GRIFFITH MO, FRANK H, 1493 E IRON, 67401
827-0488 4813750321
45 M 4813 76 OPH

GUNN MO, MARVIN R, 2142 EDGEHILL RD, 67401
3901540291
28 M 3901 63 00

HARBIN MO, GARY LYNN, 523 S SANTA FE, 67401
823-7213 1902752109
50 M 1902 77 ORS

HASSLER MO, RANDY O, 645 E IRON, 67401
827-9635 1902710465
45 M 1902 78 U

HATTON MO, LLOYD W, 709 HIGHLAND, 67401
1902330204
06 M 1902 33 00

HOOGES MO, MERLE A, PO BOX 1845, 67402
827-5451 1902580421
34 M 1902 66 OBG

HODGES MO, MERLE J, 850 S SANTA FE, 67401
827-5451 1902830843
58 M 1902 84 OBG

HOUSE MO, R E, PO BOX 2327, 67401
827-9526 1902810427
54 M 1902 82 OR

HUTCHINSON MO, OIRK T, 135 E CLAFLIN, 67401
827-9631 3901740541
48 M 3901 78 IM

JERKOVICH MO, GEORGE S, 1508 E IRON, 67401
827-1193 1902830959
57 M 1902 87 P

JETER MO, JOHN, 1500 MARYMOUNT RD, 67401
827-4411 1902810435
55 M 1902 82 EM

KELLERMAN MO, RICK, 130 W CLAFLIN BOX 1757, 67402
825-7251 1902780919
00 M 1902 81 FP

KNOX MO, JEFFREY B, 737 E CRAWFORD, 67401
827-7261 1902841039
57 M 1902 85 OBG

KREHBIEL MO, MARK A, PO BOX 1847, 67402
825-8221 1902742162
49 M 1902 76 FP

KRUCKEMYER MO, ALAN L, 645 E IRON, 67401
823-2215 1103710291
45 M 1103 77 ORS

LASSETER MO, JAMES A, 400 S SANTA FE, 67401
826-3161 1902792127
52 M 1902 80 EM

LAWRENCE MO, LINDA M, 929 ELMHURST, 67401
823-1600 8480282111
57 F 4802 86 OPH

LAWRENCE MO, MICHAEL K, 645 E IRON, 67401
827-7255 2802840520
00 M IM

LIVINGSTON MO, CHARLES E, 400 E IRON, 67401
823-9166 1611570801
32 M 1611 64 GS

MACY MO, NORMAN E, PO BOX 2027, 67402
827-4053 1902600449
35 M 1902 64 PATH

MACY MO, TEO L, PO BOX 260, 67402
827-7261 1902710660
43 M 1902 73 GS

MANGUOGLU MO, ALI B, 521 S SANTA FE, 67401
823-1032 90205760015
53 M 90205 85 N

MARCHBANKS MO, DONALD L, PO BOX 1007, 67402
1902510474
24 M 1902 51 00

MARSHALL MO, GEORGE W, PO BOX 1845, 67402
825-9024 1902700745
44 M 1902 71 OBG

MARTIN MO, OLIVER L, 715 E REPUBLIC, 67401
1902370371
08 M 1902 38 00

MATTHEWS MO, EARL H, 135 E CLAFLIN, 67401
827-9631 1902742308
49 M 1902 78 GS

MAXWELL MO, GORDON E, 135 E CLAFLIN, 67401
827-9631 1902550778
29 M 1902 55 OBG

MCCRAE MD,SPENCER C, 655 GUERNSEY OR, 67401

3509430810
18 M 3509 52 00

MILLER MD,ELDEN V, 1928 RIDGELEA, 67401

1902441031
19 M 1902 44 00

MOWERY MD,WILLIAM E, PO BOX 260, 67402

827-7261 1902470391
23 M 1902 47 GS

NELSON MD,OOUGLAS LEROY, PO BOX 2327, 67402

827-9526 1902841314
58 M 1902 87 OR

NEUMANN MD,JAMES W, 600-E SOUTH SANTA FE, 67401

825-5041 1902560820
24 M 1902 83 N

NICKELL MD,WENDELL K, 400 E IRON, 67401

823-9166 1606511201
26 M 1606 51 TS

NIXON MD,RICHARD R, BOX 2327, 67402

827-9526 1643570510
32 M 1643 65 R

NULL MD,WILLIAM G, 135 E CLAFLIN, 67401

827-9631 102570413
31 M 102 66 PD

PALMER MD,GERALO K, 1952 RIDGELEA OR, 67401

1803530765
24 M 1803 61 00

PEREZ-TAMAYO MD,CLAUDIOA, 139 N PENN, 67401

827-5591 1611812431
57 F 1611 RO

PETERSON MD,JAMES E, PO BOX 2327, 67402

827-9526 1902781451
53 M 1902 82 DR

RASMUSSEN MD,JAROLD L, 400 S SANTA FE EM OEPT, 67401

827-4411 1902740917
48 M 1902 75 EM

REECE MD,RICHARD J, 502 BEECHWOOD, 67401

1902490554
23 M 1902 49 00

RICHARDS MD,JON F, 135 E CLAFLIN, 67401

827-9631 1902752664
50 M 1902 IM

ROOERICK MD,JAMES E, 645 E IRON, 67401

827-9635 1902470511
23 M 1902 47 U

ROMEISER MD,REX S, 645 E IRON, 67401

827-9635 1902670854
41 M 1902 68 U

ROSALES MD,J EDGAR, 737 E CRAWFORD, 67401

827-7261 17601740061
00 M PO

SCHMIDT MD,RAMON WARNER, 400 E IRON, 67401

823-9166 1902650802
39 M 1902 66 GS

SCOTT MD,CHESTER E, 858 S 11TH, 67401

1902510725
23 M 1902 51 00

SEATON MD,ROBERT D, PO BOX 260, 67402

827-7261 1902781664
00 M 83 NEP

SEBREE MD,STEVEN G, PO BOX 260, 67401

827-7261 1902731047
47 M 1902 74 OBG

SHAFFER MD,JAMES J, PO BOX 676, 67401

827-0346 1902851603
00 M 1902 FP

SHERIOAN MD,KIM M, PO BOX 1966, 67402

827-3203 1902852219
56 M 1902 88 AN

SLOO MD,MILO G, 645 E IRON, 67401

823-2215 1902670889
41 M 1902 68 ORS

SMITH MD,BOYO E, BOX 2027, 67402

827-4053 3005720841
46 M 3005 78 PATH

SMITH MD,DAVID E, PO BOX 260, 67402

827-7261 1902761272
50 M 1902 77 GS

SMITH MD,HAROLD R, 608 STARLIGHT, 67401

1902510733
19 M 1902 51 00

STOSKOPF MD,LAWRENCE E, 2413 EOGHILL, 67401

823-9498 1902721084
39 M 1902 73 AN

STUEWE MD,BRAD R, PO BOX 260, 67402

827-7261 1902742022
49 M 1902 75 IM

WAGENBLAST MD,HOWARD R, PO BOX 260, 67402

1902490694
21 M 1902 49 00

WATERS MD,CLARENCE N, 833 MANOR RD, 67401

2834481114
13 M 2834 60 00

WEBER MD,ROBERT W, 645 E IRON, 67402

827-7255 1902490716
26 M 1902 49 IM

WEDEL MD,ALAN K, 1101 E REPUBLIC, 67401

823-7470 1902821933
56 M 1902 86 FP

WOODALL MD,DENNIS C, PO BOX 1847, 67402

825-8221 1902831971
55 M 1902 84 FP

SATANTA — 316 (Southwest Kansas Medical Society)

JABEL MD,JUVENAL T, SATANTA MED CNTR, 67870

649-2771 74809680111
43 M 74809 79 IM

SCOTT CITY — 316 (Northwest Kansas Medical Society)

DUNN MD,DANIEL R, 202 COLLEGE, 67871

872-2187 1902740232
49 M 1902 75 FP

HOPKINS JR MD,8 MORRISON, 804 CRESCENT, 67871

1902530408
23 M 1902 53 00

ROSIN MD,ROBERT L, 202 COLLEGE, 67871

872-2187 1902851514
58 M 1902 86 IM

SEDAN — 316 (Southeast Kansas Medical Society)

TAYLOR MD,ELMER W, 120 W OSAGE BOX 8, 67361

512570879
28 M 512 62 00

WALKER MD,WILLIAM K, 417 N MONTGOMERY, 67361

1902450722
18 M 1902 45 00

SENECA — 913 (Northeast Kansas Medical Society)

BERKLEY MD,NORMAN W, 15 SOUTH 5TH ST, 66538

336-2128 1902630054
31 M 1902 64 FP

MCGEENEY MO, TERRY L, 201 N 6TH, 66538
 336-6113 1902771774
 51 M 1902 78 FP

MENZEL MO, THOMAS E, 511 WALNUT, 66538
 336-6277 1902821241
 52 M 1902 GS

SHARON SPRINGS — 913 (Northwest Kansas Medical Society)

CHUNG MO, JOHN J, WALLACE CO MEO CL BOX 310, 67758
 852-4214 58301480022
 23 M 58301 60 FP

SHAWNEE MISSION — 913 (Johnson County Medical Society)

ALLEN MO, JAMES V, 5520 COLLEGE BLVD #410, 66211
 451-5934 2002780014
 46 M 2002 0

ALLEN MO, MAX S, 5103 W 96TH TERR, 66207
 1902370010
 11 M 1902 37 00

ALLIN MO, OENNIS M, 8623 ALOEN, 66215
 588-6500 1902830029
 57 M 1902 EM

ALTENBERNO MO, ELVIN C, 7319 W 81ST, 66204
 648-2010 1902540012
 26 M 1902 54 FP

AMA00 MO, MERCEDES C, 5520 COLLEGE BLVD STE 110, 66211
 491-3300 2803830013
 55 F 2803 88 A

ANDERSON MO, ALLISON H, 8800 W 75TH STE 220, 66204
 384-5500 1902850755
 59 F 1902 91 PO

ANDERSON MO, WILLIAM A, 2508 W 71ST, 66208
 236-7288 2846760191
 50 M 2846 83 EM

ATHON MO, MERRILL O, 6806 W 83RD, 66204
 642-4242 1902540047
 24 M 1902 54 FP

AUSTENFEL0 MO, JENNIFER, PO BOX 2923, 66201
 676-2340
 57 F 1902 89 PATH

BA0EEN II MO, LOUIS JOHN, 10600 QUIVIRA RD #460, 66215
 541-3220 2846740026
 49 M 2846 78 OPH

BAEKE MO, JOHN O, 6806 WEST 83RD, 66204
 642-4242 1902520038
 19 M 1902 52 FP

BAKER MO, WILLIAM STEVEN, 7700 W 63RD STE 209, 66204
 262-1843 702730066
 47 M 702 76 P

BALANOFF MO, ARNOLO Z, 4601 W 109TH STE 122, 66211
 491-4045 1803670061
 42 M 1803 72 PO

BALOWIN MD, THOMAS F, 8901 W 74TH STE 21, 66204
 722-0080 1902830142
 56 M 1902 84 IM

BANSAL MO, ROOPA O, 5600 W 95TH STE 105, 66207
 381-6765 49504560146
 37 F 49504 80 FP

BANSAL MO, SATISH C, 8901 W 74TH STE 147, 66204
 384-2220 49541610048
 38 M 49541 74 ORS

BAPTIST MO, JEREMY E, 5811 OUTLOOK, 66202
 432-0625 2846780729
 40 M 2846 79 A

BARE II MO, CHARLES E, 8901 W 74TH STE 353, 66204
 677-2460 1902690057
 43 M 1902 70 U

BARELLI MO, PAT A, 5609 MISSION DR, 66208
 1902440077
 19 F 1902 44 00

BARKER MO, ELIZABETH 8, 4121 WEST 83RD STE 123, 66208
 381-6669 4706550122
 30 F 4706 66 P

BARNETT JR MO, THOMAS E, 10600 QUIVIRA STE 240, 66215
 541-3355 2846750251
 52 M 1902 80 GE

BARNETT MO, THEODORE M, 6115 W 54TH TER, 66202
 234-3668
 00 M

BARNHART MO, RONALD J, 9119 WEST 74TH STE 268, 66204
 831-2334 2501680136
 41 M 2501 69 08G

BARR MO, RICHARD N, 7301 MISSION STE 119, 66208
 432-4366 1902570043
 32 M 1902 57 OPH

BARRICK MO, BRUCE, SH MSN MEO CTR PO BOX 2923, 66201
 676-2340 1902650021
 39 M 1902 66 PATH

BATTY MO, LARRY H, 9119 W 74TH STE 268, 66204
 831-2334 1902760110
 51 M 1902 77 08G

BAUER MO, LAFE W, 4818 W 80TH, 66208
 1902490023
 20 M 1902 49 00

BAUER MO, LAIRO A, 8800 W 75TH STE 300, 66204
 722-4240 1902860106
 56 M 1902 89 IM

BEAMON MO, RICHARD F, 8000 W 110TH STE 105, 66210
 469-1411
 47 M 2803 91 EM

BECKER MO, NANCY J, 5520 COLLEGE BLVD #350, 66211
 661-9980 1902820139
 48 F 1902 87 IM

BEEZLEY MO, MICHAEL J, 8800 W 75TH STE 115, 66204
 262-9201 1902730105
 47 M 1902 74 GPVS

BELL MO, O W, 7000 W 121ST ST, SUITE 100, 66209
 469-1020 1902680078
 42 F 1902 69 OPH

BELT MO, ROBERT J, 12000 W 110 #400, 66210
 469-8023 702710073
 45 M 702 75 ON

BELZER MO, EDWARD G, 10600 QUIVIRA STE 330, 66215
 541-3300 3005620081
 36 M 3005 67 PO

BICHLMEIER MO, FRANKLIN G, 8901 W 74TH STE 272, 66204
 362-0500 1902580081
 33 M 1902 59 GS

BILLINGSLEY MO, THAO H, 4501 COLLEGE BLVD #350, 66211
 661-9669 1902660115
 41 M 1902 67 P

BISHOP MO, FRANCIS E, 3208 W 83 TERR, 66206
 1902450064
 20 M 1902 45 00

BISHOP MO, HENRY R, 10600 QUIVIRA STE 320, 66215
 541-3200 4813790128
 53 M 4813 82 08G

BLETZ MO, DONALD 8, 10550 QUIVIRA STE 510, 66215
 492-6200 5104580116
 28 M 5104 72 IM

BOHN MO, WILLIAM W, 10550 QUIVIRA STE 350, 66215
 888-9893
 55 M ORS

BOLES MO, J MICHAEL, 5949 NIEMAN, 66203
 631-1300 1902610088
 35 M 1902 62 FP

BOTTS MD, LARRY D, 8901 W 74TH #348, 66204 432-800D 3005790092 52 M 3007 PUD	COX JR MD, IRA, 5829 WOODSON PO BOX 975, 66202 722-11D0 190249D18D 19 M 1902 49 FP
BROWN MD, WILLIAM R, 73D1 MISSION STE 339, 662D8 236-8866 190248D079 23 M 1902 48 IM	COX MD, GLENDON G, 10500 QUIVIRA RO, 66215 541-5384 19028D0243 55 M 1902 84 OR
BROXTERMAN MO, STEVEN JOSEPH, 9119 W 74TH STE 150, 66204 362-5510 1902760217 51 M 1902 77 FP	CRDCKETT MO, CHARLES A, 4820 W 81ST, 66208 324-2200 40144D178 19 M 401 49 OPH
BRUN MO, MICHAEL E, PO BOX 29194, 66201 676-2310 2802810141 55 M 2802 86 OR	OARR MD, RICHARD 8, PO BDX 2923, 662D1 676-2097 3401700047 42 M 3401 72 IM
BRUNING MD, DANIEL L, 11364 W 121ST TERR, 66213 268-0500 283482D105 56 M 2834 84 AN	OAVIA MD, JAMES E, 10550 QUIVIRA STE 510, 66215 492-6200 1611620361 37 M 1611 85 CD
BRUNING MO, ROGER MARION, 7301 MISSION STE 342, 662D8 384-0745 1902760225 48 M 1902 79 FP	OEITZ MD, MICHAEL R, 5700 8RDADMODR OR STE 912, 662D2 432-0212 4101580216 32 M 4101 62 OPH
BUBB MO, STEPHEN K, 8901 W 74TH STE 3, 66204 362-0031 190274D135 48 M 1902 76 ORS	DENISDN MD, TERRY R, 5811 OUTLOOK, 66202 432-0625 1902560307 29 M 1902 56 A
BUCKMAN MD, MARTIN SPALDING, 10600 QUIVIRA STE 240, 66215 541-3355 280376D066 49 M 28D2 75 IM	DENNIS MD, MICHAEL W, PO BOX 29194, 66201 676-2310 57 M 2846 83 OR
BURES JR MO, GEORGE J, 8700 8DURGAOE STE 2, 66219 599-5500 58 M 1902 90 FP	OERRINGTON MD, KENNETH L, 4601 W 109TH STE 310, 66211 491-6464 190271D287 44 M 1902 72 FP
BURGER MD, PAUL 8, 5638 NIEMAN RO PO BDX 3278, 66203 631-6114 28345D0101 25 M 2834 50 FP	DIEHL MO, ANTONI M, 13106 W 75TH TERR, 66216 24 M 2604 53 00
BUSER MD, WILLIAM D, 12000 W 110TH STE 2D0, 66210 469-1477 19028D0146 55 M 1902 83 GE	DOCKHORN MO, ROBERT J, 5300 W 94TH TERR, 66207 381-4674 1902600236 34 M 1902 61 PDA
BUTRICK MO, CHARLES W, 10600 QUIVIRA STE 320, 66215 541-3200 55 M 1902 88 OBG	OONLEY MD, JAMES L, 8340 MISSION RO STE 201, 66206 648-2892 1902720347 46 M 1902 73 P
CALKINS MD, LARRY L, 5635 SUWANEE, 66205 190243D187 18 M 1902 43 00	DRAHOTA MD, LAWRENCE J, 10550 QIOVORA, 66215 492-6200 3005820391 56 M 3005 83 GS
CAMPBELL JR MO, WILLIAM R, 9515 W 117TH ST, 66210 345-1220 1902820287 55 M 1902 83 GS	DRAKE MD, CYNTHIA K, 9119 W 74 #30D, 66204 677-150D 2846810181 57 F 1902 83 DBG
CASTEEL MD, CHARLES K, 8901 W 74TH STE 32, 662D4 831-1003 390159D141 34 M 3901 64 U	DRASIN MD, OENA K, 7301 MISSION RD STE 328, 66208 362-1444 2002800341 4D F 2002 85 CHP
CATTANEO MO, ERNEST A, 8901 W 74TH ST #149, 66204 262-3930 1902650110 39 M 1902 66 IM	DREILING MD, ROGER J, 8901 W 74TH STE 21, 66204 722-0080 1902780552 51 M 1902 79 CD
CEDERLINO MO, CRANSTON JAY, 8901 W 74 STE 36, 66204 236-6455 1902710198 45 M 1902 72 OBG	DUCKETT II MD, THOMAS G, 7DOD W 121 ST #110, 66209 469-1020 1902670145 41 M 19D2 68 OPH
COHEN MO, ROBERT A, 370D W 83RD STE 110, 66208 642-2100 2803640036 39 M 2803 70 PD	DUDGEON MD, MAUREEN, 8901 W 74TH STE 124, 66204 362-2035 1902770417 51 F 19D2 78 IM
COLEMAN MD, ROBERT L, 8901 W 74TH STE 1, 66204 362-010D 4113660193 41 M 4113 79 PS	DUNCAN MD, KIRK A, 88D0 W 75TH STE 115, 66204 474-9353 1902780561 53 M 19D2 83 NEP
COOLEY MD, DAVIO A, 5520 CDLLEGE STE 350, 66211 661-998D 2802660131 40 M 2802 72 RHU	DURKEE MD, BRUCE W, 1D55D QUIVIRA STE 510, 66215 492-62D0 190279D574 52 M 1902 82 AN
COOPER MD, JACK R, 5300 MISSION RO, 66205 3840430251 17 M 3840 52 OD	DYCK MO, ERIC LEE, 5799 BRDADMOOR 2ND FL, 66202 541-5200 1902770433 52 M 1902 80 FP
CORDELL MD, LARRY D, 12301 W 106TH ST STE 1D0, 66215 888-2800 41 M 1902 90 DRS	ELLIS MD, S CHRISTDPHER, PD BOX 23548, 66223 373-D263 91707710051 47 M 917D7 85 AN
CDULTER MD, HENRY F, 4203 W 151 ST, 66224 1902510113 23 M 1902 51 00	ELLIS MD, HDWARD D, 1D550 QUIVIRA STE 410, 66215 541-0990 1902780579 53 M 1902 89 08G
COULTER MD, THOMAS B, 7504 ANTIOCH, 662D4 341-D931 1205640165 38 M 12D5 72 DPH	EMMOTT MD, DAVID F, 89D1 W 74TH STE 32, 66204 831-1003 39D1790476 53 M 3901 81 U

ANDERS MO, WRAY, 9034 COTTONWOOD OR STE 2, 66215
 1902360138
 02 M 1902 36 00
 ESRIG O O, HAROLO L, 8132 SAGAMORE, 66206
 2878600013
 30 M 2878 62 00
 ETZENHOUSER III MO, RUSSELL O, 10600 QUIVIRA STE 330, 66215
 541-3300 1902590273
 34 M 1902 64 PD
 EVANS JR MO, WILLIAM E, 7301 MISSION RD #208, 66208
 362-7363 1902580294
 24 M 1902 59 FP
 EVANS MO, CAROL ANN, 8901 W 74TH STE 124, 66204
 362-0000 2846780222
 54 F 2846 82 IM
 FRANCISCO MO, CLARENCE L, 3509 W 85TH, 66206
 1902340145
 09 M 1902 34 00
 FRANKEL MO, SCOTT J, 4601 W 109TH STE 318, 66211
 491-5501 2802790387
 53 M 2802 84 A
 FRIESEN MO, STANLEY R, 48 LE MANS CT, 66208
 1902430306
 18 M 1902 43 00
 GAGE MD, BETSE M, 8800 W 75TH ST #220, 66204
 384-5500 1902800375
 55 F 1902 84 PO
 GALLEHUGH MO, KEITH W, 9027 BIRCH, 66207
 1902570281
 32 M 1902 57 00
 GARCIA-FERRER MO, FRANCISCO, 10616 W 87TH ST, 66214
 642-5000 27501601638
 32 M 27501 73 FP
 GAUGHAN MO, MICHAEL J, 11880 COLLEGE BLVD STE 410, 66201
 469-8998 1902741549
 49 M 1902 77 R
 GENTRY MO, KALE C, 6806 W 83RD, 66204
 642-4242 1902600244
 31 M 1902 60 FP
 GERJARUSAK MO, PRAPAS, 8901 W 74TH STE 121, 66204
 262-0344 89104710086
 46 M 89101 75 IM
 GERWICK MD, CHARLES L, 9100 W 74TH ST, 66201
 676-2214
 58 M 1902 91 EM
 GIBBONS MO, ROBERT T, 8800 BALLENTINE, 66214
 894-4050 1902680302
 43 M 1902 69 AN
 GILLEN MO, BILLY A, 8802 BIRCH LN, 66207
 1902540365
 29 M 1902 54 00
 GOERTZ MD, LEO R, 6340 ASH, 66208
 1902520275
 22 M 1902 52 00
 GOLOSTEIN MO, GERALD L, 4500 COLLEGE BLVD STE 200, 66209
 491-5501 16504760069
 47 M 16504 81 P
 GOMEZ MO, FRANCISCO, 2020 DRURY LN, 66208
 649-7300 26401400019
 15 M 26401 63 P
 GOOD MD, WENOELL Lisle, 4601 W 109TH STE 212, 66211
 491-9183 1902480214
 24 M 1902 48 FP
 GOODWIN MD, JOHN A, 10600 QUIVIRA STE 330, 66215
 541-3300 1902860645
 60 M 1902 88 PO
 GRASHOFF MO, JOYCE A, 11116 W 114TH, 66210
 596-4180 3005800101
 59 F 3005 83 EM
 GRAY MO, C K, 11020 KING, 66210
 345-2622 1902753067
 48 M 1902 75 IM
 GRIN MO, TRUDI R, 10550 QUIVIRA STE 335, 66215
 888-1888
 57 F 2846 86 PO
 GROSSMAN MD, HARVEY M, 4601 W 109TH STE 122, 66211
 491-4045 1902742243
 49 M 1902 77 PO
 GRUNOMEIER MO, ANNETTE M, 9119 W 74TH STE 210, 66204
 432-3334 1611770916
 46 F 1611 79 PO
 HACKER MO, OAVIO C, PO BOX 2923, 66201
 676-2479 1902752079
 50 M 1902 78 AN
 HALL MD, MARK R, 9100 W 74TH ST, 66201
 676-2214
 60 M 2512 90 EM
 HALLERAN III MO, WILLIAM J, 11880 COLLEGE BLVD STE 410, 66201
 469-8998 1902780749
 53 M 1902 80 DR
 HAMTIL MO, LAWRENCE W, 10550 QUIVIRA RD STE 460, 66215
 341-3937 2803610251
 36 M 2803 69 PO
 HARDIN MO, CREIGHTON A, 8229 NALL AVE, 66208
 5605430432
 18 M 5605 48 00
 HARRIS MD, LANNY W, 10550 QUIVIRA STE 350, 66215
 888-9893
 41 M 4706 ORS
 HARRIS MO, MARGARET H, 10600 QUIVIRA STE 320, 66215
 541-3200 1902840725
 58 F 1902 OBG
 HARTMAN MO, GERALD V, 6616 EL MONTE, 66208
 1902450331
 20 M 1902 45 00
 HARTONG MO, TOBY JOSEPH, 8901 W 74TH STE 328, 66204
 384-1441 1902780765
 53 M 1902 83 OPH
 HARTONG MO, WILLIAM A, 8901 W 74TH STE 372, 66204
 831-9300 1902710457
 44 M 1902 72 IM
 HEISLER MD, NORMAN T, 8901 W 74TH STE 269, 66204
 362-4040 3005800632
 55 M 3005 84 P
 HENRY MO, JOSEPH E, 8901 W 74TH STE 348, 66204
 00 M
 HESSER MO, HERBERT H, 6555 W 75TH ST A #339, 66204
 1902340242
 06 M 1902 34 00
 HETTINGER MO, MICHAEL E, 7504 ANTIOCH, 66204
 341-3100 4706750431
 46 M 4706 81 OPH
 HILL MO, ROONEY W, 8901 W 74TH STE 208, 66204
 362-0300 1902741573
 47 M 1902 75 IM
 HITCHCOCK MO, C THOMAS, 8901 W 74TH STE 356, 66204
 677-2508 1902730521
 47 M 82 GS
 HOBSON MO, MILBURN W, 9119 W 74TH STE 268, 66204
 831-2334 1902550522
 30 M 1902 55 OBG
 HOOES MD, HERBERT C, 4840 COLLEGE STE 100, 66211
 491-6678 1902690553
 43 M 1902 70 OBG
 HOLMAN MO, JON B, 6000 LAMAR, 66202
 782-2100 1902630364
 33 M 1902 64 P
 HOLMES MD, JOHN A, 5555 E 58TH ST, 66202
 432-2080 1902770654
 47 M 1902 78 IM
 HOOD MO, ROGER W, 8300 COLLEGE STE 105, 66210
 451-9310 1643740431
 48 M 1643 76 ORS

HOPKINS MD, LENLY, 7312 ANTIOCH, 66204
722-6121 3841560344
30 M 3841 65 GS

HOPKINS MD, WILLIAM O, 8575 W 110TH STE 306, 66210
451-1919 2803610358
33 M 2803 72 ORS

HOUSTON II MD, LAWRENCE MORLEY, 5520 COLLEGE BLVD #460,
66211
451-1311 2803760449
50 M 2803 79 FP

HSU MD, CECILIA C, 10550 QUIVIRA RD #280, 66215
888-9129
43 F 24402 84 PD

HUMPHREY MD, MARK S, 10600 QUIVIRA RD STE 230, 66215
541-8897 1902840890
58 M 1902 85 ORS

HUSEMAN MD, RICHARD ALLAN, 8901 W 74TH STE 357, 66204
831-2430 1720720961
46 M 1720 75 NEP

INNES MD, ROBERT C, 10226 BRIAR, 66207
2802490294
25 M 2802 66 00

JACKSON MD, ROBERT V, 8901 W 74TH STE 10, 66204
362-1660 2803770401
49 M 2803 80 PD

JANES MD, DONALD R, 10550 QUIVIRA #310, 66215
492-1955 1902600350
34 M 1902 62 OBG

JOHNSON MD, JOHN C, 8901 W 74TH ST STE 145, 66204
722-0020
56 M 2846 90 OTO

JOHNSON MD, PAMELA M, 8901 W 74TH STE 10, 66204
362-1660
58 F 1902 87 PD

JONES MD, CHARLES E, 9100 W 74TH PO BOX 2923, 66201
676-2214 1902600368
31 M 1902 61 FP

JONES MD, H IVOR, 8901 W 74TH STE 269, 66204
362-4040 80303510072
24 M 80303 59 P

KARLIN MD, CHARLES A, 11880 COLLEGE BLVD STE 410, 66201
469-8998 1902752265
49 M 1902 76 DR

KASHYAP MD, ANSHI PRASAO, 8901 W 74TH STE 257, 66204
236-4500 49554710017
47 M 49554 78 IM

KATZ MD, ARNOLD L, 10550 QUIVIRA RD #470, 66215
888-3231
44 M 5101 RHU

KATZ MD, FRED S, 8901 W 74TH STE 145, 66204
722-0020 1902791066
00 M 1902 58 OTO

KELLEY MD, GOROON R, 8800 W 75TH STE 100, 66204
491-4330 6002770014
52 M 6002 83 N

KENNY MD, LAURA M, 9119 W 74 #300, 66204
677-1500 1902831009
56 F 1902 87 OBG

KETCHUM MD, LYNN D, 12301 W 106TH STE 201, 66215
492-3737 2101600524
36 M 2101 69 PS

KOCH MD, KEVIN J, 9100 W 74TH, 66201
676-2214
55 M 2846 89 EM

KODANAZ MD, A AYTEKIN, 5710 REINHARDT DR, 66205
596-4100 90201550695
28 M 90201 70 AN

KOZIKOWSKI MD, BEN M, 7301 MISSION RD STE 348, 66208
362-8317 2834550477
30 M 2834 62 ORS

KRUEGER MD, KURT ALLEN, PO BOX 2923, 66201
676-2479 3006740536
48 M 3006 78 AN

KUBIN MD, DORIS A, 2504 W 71ST, 66208
1902430446
15 F 1902 43 00

KUEBLER MD, KEVIN M, 9359 W 75TH, 66204
341-0120 2101750658
50 M 2101 82 COTS

KURTH MD, ROBERT H, 5555 W 58TH, 66202
432-2080 3005530376
28 M 3005 59 IM

LAPI MD, ANGELO, 2012 STRATFORD RD, 66208
262-9020 3506370239
13 M 3506 PATH

LAPI MD, RUTH M, 2012 STRATFORD RD, 66208
4107370141
14 F 4107 50 00

LARSON MD, DANUTA OKTAWIEC, 5848 FONTANA DR, 66205
22 F 80303 61 00

LASH MD, RAY E, 8901 W 74TH STE 21, 66204
722-0080 1902752338
50 M 1902 76 CD

LEAHY MD, JAMES D, 12210 W 87 PARKWAY #135, 66215
342-7184 3005790823
48 M 3005 PS

LEE MD, JAMES G, 5700 METCALF CT, 66202
1902440867
18 M 1902 44 00

LEGASPI JR MD, PEDRO L, 9100 W 74TH PO BOX 2923, 66201
676-2479 74801600127
36 M 74801 71 AN

LEMOINE JR MD, ALBERT N, 6117 W 119 #3130, 66209
2802430992
18 M 2802 47 00

LEO MD, WILLIAM A, 4505 W 66TH, 66208
1902520445
22 M 1902 52 00

LESTER MD, JOHN BUCKLES, 4140 W 71ST STE 108, 66208
432-7276 1902700681
45 M 1902 71 P

LEVINE MD, HOWARD T, 5520 COLLEGE BLVD STE 110, 66211
491-3300 2101850776
59 M 2101 89 A

LEWIN MD, WALTER, 8901 W 74TH STE 269, 66204
362-4040 1902560668
30 M 1902 56 P

LIPSEY MD, JAMES H, 9119 W 74TH STE 350, 66204
831-3500 1606560687
31 M 1606 73 ORS

LOCKWOOD MD, TED E, 10600 QUIVIRA RD #470, 66215
894-1177
45 M 1902 91 PS

LOTUACO MD, GAMALIEL G, 5520 COLLEGE BLVD #232, 66211
491-6373 74801641184
41 M PS

LUND MD, STEPHEN B, 9100 W 74TH ST, 66201
676-2214 2604731529
47 M 2604 89 EM

MACARTHUR MD, RICHARD I, 10550 QUIVIRA STE 510, 66215
492-6200 1902730709
46 M 1902 74 COTS

MALLORY MD, JOHN A, 10600 QUIVIRA STE 210, 66215
541-3340 2803710476
43 M 2803 75 IM

MANTZ MD, FRANK A, 9309 W 103RD, 66212
4101380691
12 M 4101 61 00

MARTIN MD, MELANIE A, 8901 W 74TH #36, 66204
236-6455 1902851166
58 F 1902 89 OBG

MASTERS MD, FRANCIS W, 6738 RAINBOW, 66208
3545450321
20 M 3545 58 00

MATHEWS MO, ROBERT MAJOR, 1D308 METCALF/MAIL SERV INC,
66212
469-0030 1902540608
25 M 1902 54 GS

MAXWELL MD, ROBERT A, 8901 W 74TH STE 10, 66204
362-1660 1902730741
46 M 1902 75 PO

MCCAUGHEY MO, HUGH W, 11055 CEOAR STE 217, 66211
491-3724 1902530572
28 M 1902 53 IM

MCLLAIN MD, STEVE A, 9100 W 74TH ST, 66201
676-2340 2803821235
53 M 2803 90 PATH

MCCOWEN MD, HERBERT M, 10100 W 119TH STE 275, 66213
491-1616 1902851221
58 M 1902 FP

MCCUNE MD, MARK A, 10600 QUIVIRA RD STE 430, 66215
541-323D 1902770883
52 M 1902 81 D

MCEACHEN MO, WILLIAM H, 3700 WEST 83RD STE 102, 66208
649-3335 1902590575
32 M 1902 60 PO

MCGRATH MO, BARBARA A, 7509 NALL AVE, 66208
381-5544 4109750889
49 F 4109 86 PS

MCGUIRE MO, THOMAS H, 10600 QUIVIRA RD, 66215
541-320D
32 M 1902 OBG

MCMURRAY MO, LAURA J, 10550 QUIVIRA #410, 66215
541-0990 1902831220
57 F 1902 OBG

MIGLIAZZO MO, CARL V, 7504 ANTIOCH, 66204
341-3100 2803790763
49 M 2803 85 OPH

MILLER MO, FREEMAN LANCE, 10550 QUIVIRA STE 340, 66215
492-1111 1902742316
48 M 1902 77 PO

MINGLE MD, RALPH R, 9119 W 74TH STE 15D, 662D4
362-5510 1902801274
54 M 1902 81 FP

MISKEW MD, DON B W, 7301 MISSION STE 348, 66208
362-8317 650669D020
42 M 6506 8D ORS

MOFFAT MO, ROBERT E, PO BOX 29194, 66201
469-0094 1902680680
42 M 1902 69 DR

MORITZ MD, RICK S, 12316 NIEMAN RD, 66213
371-4343 1902781320
54 M 1902 81 DR

MORDNEY MD, JEAN M, 10550 QUIVIRA STE 51D, 66215
492-62D0 4107650356
25 F 4107 68 N

MUEHLBERGER MD, JAMES J, 4601 W 1D9TH STE 314, 66211
491-3242 30066DD360
34 M 3006 7D PD

MURPHY MD, JAY W, 8901 W 74TH STE 21, 66204
722-D08D 3840733016
49 M 3840 74 CD

MURRAY MD, W LEE, 1055D QUIVIRA RD STE 270A, 66215
599-2888 190261D614
35 M 1902 78 OPH

NARRO MD, JOHN P, 89D1 W 74TH, 662D4
262-D344
58 M 4814 9D ID

NASH MD, ROBERT A, 11111 NALL STE 2DD, 66211
491-6686 190255D832
31 M 1902 55 P

NAUER MO, PAULA LOU, 73D1 MISSIDN RD STE 342, 66208
384-0745 1902742324
49 F 1902 78 FP

NAVICKAS MD, LEONARD A, 9119 W 74TH STE 150, 66204
362-5510 19D2771057
53 M 19D2 78 FP

NAZARIO MO, LILIANA E, 10100 W 119TH STE 275, 66213
491-1616
57 F 19D2 87 FP

NEIBURGER MD, JAMES B, 5520 COLLEGE BLVD #110, 66211
491-3300 164272D518
46 M 1642 75 A

NEIGHBOR MD, ERNEST H, 8612 REINHAROT LANE, 66206
831-3433 190266D751
40 M 19D2 67 ORS

NELSON MD, BRYAN C, 8800 W 75TH ST #220, 66204
384-550D 1902752508
50 M 1902 78 PO

NORTON MD, KENNETH A, 8901 W 74TH STE 333, 66204
262-9311 1902752532
50 M 1902 86 IM

NOSTI MO, JUAN C, 8901 W 74TH STE 345, 66204
262-5014 13204630D83
38 M 13204 72 PS

NOTHNAGEL MO, ARNOLO F, 9936 EOELWEISS CIR, 66203
1902390398
15 M 1902 39 00

NYE MD, C ERIK, 7301 MISSION RD STE 348, 66208
362-8317 3520650571
39 M 352D 78 ORS

O'BRYAN MD, JAMES J, 5300 W 94TH TERR, 66207
381-4674 1902730831
47 M 1902 PD

OLSON MD, THOMAS H, 8901 W 74TH STE 10, 66204
362-1660 300579103D
54 M 3005 84 PO

DWENS MD, DAVIO B, 10600 QUIVIRA RD #44D, 66215
492-1844 3006760634
5D M 3006 83 OBG

OXLER JR MD, JOHN EDWARD, 8800 W 75TH STE 300, 66204
722-4240 1902720894
46 M 1902 74 IM

PARR MD, CATHERINE, 1055D QUIVIRA RD K #410, 66215
541-0990 1902771146
52 F 1902 80 OBG

PATTERSDN MD, JOHN R, 5317 CHADWICK RD, 66205
1902480362
20 M 1902 48 00

PAZELL MD, JOHN A, 1221D W 87TH PKWY, 66215
541-0509 2501661247
40 M 2501 73 ORS

PEARCE MD, LUNETTA M, 9119 W 74TH STE 208, 66204
362-1525 3D0549D455
26 F 3005 52 FP

PENTECOST MD, RICHARD L, 6620 RIGGS, 66202
1001560626
32 M 10D1 65 00

PETELIN MD, JDSEPH B, 9119 W 74TH STE 355, 66204
432-5420 1902761043
49 M 1902 81 GPVS

PETERSEN MD, GERALD D, 4121 W 83RD ST, 66208
648-3911 1902600635
30 M 1902 66 IM

PFUETZE MD, BRUCE L, 11725 W 112TH, 66210
469-5579 1902680795
42 M 1902 69 A

PFUETZE MD, KARL O, 1D550 QUIVIRA STE 510, 66215
492-6200 1902660832
40 M 1902 67 CD

PHILLIPS MD, WARREN G, 3700 W 83RD STE 2D3, 66208
649-0923 1902600643
26 M 1902 63 P

PILCHARD MD, WILLIAM A, 8901 W 74TH STE 25, 66204
362-3210 1602650436
39 M 1602 72 OPH

PINGLETON MD,WILLIAM W, 8901 W 74TH STE 348, 66204

OD M

PIPPIN MD,LYNNE K, 17409 W 66TH TERR, 66217

281-8400 35207720036
48 F 35207 72 AN

PITTS MD,RONALD L, 8901 W 74TH STE 330, 66204

362-2524 2002620831
35 M 2002 72 D

PORTO JR MD,ANTHONY F, 10550 QUIVIRA STE 120, 66215

894-9125 3006750604
50 M 3006 85 ENT

POWELL MD,CAROL W, 8216 CHEROKEE CIR, 66206

381-3785 1902510652
25 F 1902 51 P

POWELL MD,KENNETH A, 8216 CHEROKEE CIR, 66206

381-3785 1902530688
25 M 1902 53 IM

PRENDES MD,CARLOS A, 6540 W 95TH, 66212

381-5550 3005791099
50 M 3005 81 FP

PRONKO MD,MICHAEL J, 4121 W 83RD STE 223, 66208

648-7878 1902600660
34 M 1902 61 P

PROUD MD,G ONEIL, 3721 W 87TH, 66206

2802390664
13 M 2802 50 00

QUIGLEY MD,JAMES, 9100 W 74TH PO 80X 2923, 66201

676-2340 2803771165
50 M 2803 84 PATH

QUINN MO,JOHN MICHAEL, 10550 QUIVIRA STE 240, 66215

492-3443 2846810512
57 M 2846 87 PS

REED JR MD,WILLIAM O, 8901 W 74TH STE 225, 66204

831-2604 2803771131
50 M 2803 83 ORS

RICE MO,BERNARD F, 8901 W 74TH STE 125, 66204

262-9222 4113560989
31 M 4113 79 ENO

RICHARDSON II D O,LESTER E, 9100 W 74TH, 66201

676-2214 3875830201
53 M 3875 90 EM

RICHAROSON MD,JAY L, 10550 QUIVIRA RO, 66215

492-6200 1902650748
38 M 1902 66 GS

RICHTER MO,00N G, 9100 W 74TH PO BDX 2923, 66201

676-2679 1902761116
50 M 1902 79 AN

RICK JR MD,GREGORY G, 8901 W 74TH STE 372, 66204

831-9300 1902660867
40 M 1902 67 GE

RIEKHOF MO,PAUL L, 10600 QUIVIRA STE 320, 66215

541-3200 2803650627
40 M 2803 08G

RIFFEL MD,LAWRENCE D, 10600 QUIVIRA STE 210, 66215

541-3340 1902781567
53 M 1902 81 IM

ROBERTSON MD,EOWARD J, 9100 W 74TH PO BOX 2923, 66201

676-2479 1902761124
46 M 1902 78 AN

ROBINSON MO,DAVIO W, 7930 BRISTOL CT, 66208

4101380985
14 M 4101 40 00

RDBINSON MO,JOHN D, 9100 W 74TH PO 80X 2923, 66201

676-2479 1902741743
48 M 1902 75 AN

ROSENBERG MO,STANTON L, 1900 W 75TH STE 200, 66208

362-8080 1902550972
3D M 1902 55 P

ROSENTHAL MO,RICHARD H, 10500 QUIVIRA RD, 66212

469-1411 2846760281
50 M 2846 IM

RUBIN MD,HERBERT M, 10550 QUIVIRA STE 340, 66215

492-1111 2803630511
37 M 2803 72 PD

RYAN MD,MICHAEL E, 8800 W 75 #100, 66204

384-4200 1902720975
46 M 1902 73 N

RYMER MD,ROBERT A, 8901 W 74TH STE 373, 66204

722-0170 702680581
41 M 702 80 OPH

SAFFO MD,KARL S, 8901 W 74TH STE 176, 66204

362-9585 52801620132
39 M 52801 73 PS

SATHYANARAYANA MD,SARASWATHI, 8901 W 74TH STE 20, 66204

677-2281 49509670144
45 F 76 DBG

SAWKAR MD,LAXMIDAS A, 8901 W 74TH #312, 66204

384-4844 49523660046
36 M 49523 74 ON

SAXER MD,JOHN J, 12902 STATE LINE, 66209

451-4443 1643850997
59 M 1643 87 FP

SCHAEFER MD,JDSEPH PETER, 10550 QUIVIRA STE 230, 66215

492-7440 1902600724
34 M 1902 61 IM

SCHLICHTER MD,KIMBERLY A, 9119 W 74TH STE 268, 66204

831-2334 2834821331
56 F 1902 87 OBG

SCHREPFFER MD,ROSEMARY, 6401 ENSLEY LN, 66208

1902470553
22 F 1902 47 08G

SCHROLL MD,JOHN T, 8901 W 74TH STE 248, 66204

384-4990 1902761213
51 M 1902 77 08G

SCHUTZ MD,RALPH A, 10500 QUIVIRA RD (EM), 66215

541-5000 1902821704
51 M 1902 EM

SCLAR MO,WILLIAM C, 10600 QUIVIRA STE 400, 66215

491-3240 2501721720
46 M 2501 79 GS

SETTLE JR MO,RUSSELL O, 8717 W 110TH STE 350, 66210

451-0430 1902600767
35 M 1902 61 P

SHAAD MO,00ROTHY J, 2322 W 51ST, 66205

1902441341
09 F 1902 44 00

SHAFFER MO,KATHLEEN BRAY, 8800 W 75TH ST #250, 66204

384-5500 2846790031
54 F 2846 82 PO

SHERIOAN MD,RAN0Y M, 8901 W 74TH STE 36, 66204

236-6455 1902781681
53 M 1902 81 OBG

SHIMSHAK MO,KAREN S, 10550 QUIVIRA #335, 66215

888-1888
59 F 5606 P00

SHOFSTALL MO,WILLIAM H, 67D1 WEST 56TH, 66202

39D141D452
11 M 3901 51 00

SHORT MD,BRUCE HERSCHEL, 10600 QUIVIRA RD STE 210, 66215

541-3340 1902771341
51 M 1902 88 IM

SIFERS MD,TIMOTHY M, 8901 W 74TH STE 356, 66204

677-2508 1902741760
48 M 1902 75 GS

SILVER MD,BRADD J, 8800 W 75TH STE 101, 66204

362-2035 1205760811
50 M 1205 77 IM

SIMON MO,STEVEN M, 5701 W 110TH, 66211

491-2400 30501830310
47 M 30501 84 PM

SIMONE MD,JOSEPH N, 8901 W 74TH STE 25, 66204

362-3210 1902831670
49 M 1902 87 OPH

SINCLAIR MO,RICHARD H, 10600 QUIVIRA RD STE 320, 66215 541-3200 37 M 2834 75 OBG	TRETBAR MO,LAWRENCE L, 8901 W 74TH STE 300, 66204 677-1776 1902600881 33 M 1902 67 GS
SMITH MO,0ONALO J, 8800 W 75TH ST #140, 66204 642-4515 1902490635 18 M 1902 49 FP	TUCKER MD,SHERIOAN G, 5520 COLLEGE BLVO #320, 66211 451-2227 1902752940 50 M 1902 77 CHP
SMITH MO,WILLIAM P, 11880 COLLEGE BLVO STE 410, 66201 469-8998 1902771405 51 M 1902 79 R	VALK MD,WILLIAM L, 5401 W 81ST, 66208 2501370790 09 M 2501 46 00
SNOOELL MO,FIRMIN E, 5555 W 58TH, 66202 432-2080 1902610754 31 M 1902 62 IM	VANNAMAN MD,DONALD O, 10600 QUIVIRA STE 330, 66215 541-3300 1902711135 43 M 1902 72 PO
SNOW JR MO,ARTHUR D, 9119 W 74TH STE 150, 66204 362-5510 1902752800 45 M 1902 76 FP	VOONICK MO,DAVID S, 9100 W 74TH ST PO BOX 2923, 66201 676-2214 1902801584 50 M 1902 90 EM
STAMOS MO,GEORGE E, 10600 QUIVIRA RO, 66215 541-3340 1803721099 46 M 1803 IM	WALO MD,JEFFREY A, 4601 W 109TH #318, 66211 491-5501 2803800980 54 M 2803 89 A
STEINZEIG MD,SHERMAN M, 2200 W 75TH ST #213, 66208 1902520640 25 M 1902 52 00	WALKER MO,JACK D, 7903 W 118TH TER, 66210 1902530912 22 M 1902 53 00
STEVENSON MO,E KENT, 4121 W 83RD STE 150, 66208 649-5566 2802670675 45 M 2802 74 P	WANG MO,SIONEY W, 10550 QUIVIRA STE 130, 66215 492-1500 38503570049 32 M 38503 70 FP
STITES MO,SANORA R, 10600 QUIVIRA STE 320, 66215 541-3200 2803860940 60 F 2803 90 OBG	WAXMAN MO,DAVID, 12516 W 85TH TERR, 66215 588-1227 3515500358 18 M 3515 70 IM
STRICKLAND MO,JOHN T, 8901 W 74TH STE 32, 66204 831-1003 2803840965 58 M 2803 89 U	WEBB MD,JAMES R, 5949 NIEMAN RO, 66203 631-0900 1902610851 34 M 1902 62 FP
STRIEBINGER MO,CHARLES M, 9119 W 74TH #303, 66204 432-1100 1606711197 45 M 1606 77 NS	WEIGHARO MO,MICHAEL, 9100 W 74TH, 66201 676-2214 1720792881 54 M 1720 90 EM
STUBER MD,JACK L, 11880 COLLEGE #410 PO BOX29194, 66201 676-2310 1902661006 40 M 1902 67 OR	WEINGART MD,JAMES H, 7315 FRONTAGE RD #100, 66204 648-5600 1902841926 58 M 1902 87 FP
STUCKEY MO,CHARLES E, 10600 QUIVIRA STE 350, 66215 541-3377 3005680815 41 M 3005 80 GS	WHITAKER MO,MARK A, 10550 QUIVIRA #340, 66215 492-1111 1902771596 53 M 1902 PO
SUGAR MD,ROBERT L, 8901 W 74TH STE 248, 66204 384-4990 3508661401 40 M 3508 72 OBG	WHITEHEAD MO,RICHARD E, 7301 MISSION RD SUITE 348, 66208 362-8317 2501581618 31 M 2501 65 ORS
SULLIVAN JR MO,HENRY B, 5817 NIEMAN RD, 66203 631-6160 1902520666 24 M 1902 52 FP	WHITFIELD MO,STEVEN S, 8901 W 74TH STE 21, 66204 722-0080 56 M 1902 CO
SULLIVAN MD,TOM G, 10600 QUIVIRA STE 320, 66215 541-3200 1902711101 44 M 1902 75 OBG	WHITLEY MO,DOUGLAS M, 4601 W 109TH SUITE 202, 66211 491-3376 1902600953 34 M 1902 61 O
TAYLOR MO,THOMAS F, 13347 W 105TH C/O ONL HALSEL, 66215 1902530858 26 M 1902 53 00	WIEGHARO MD,CHARLES M, 9100 W 74TH ST, 66201 676-2214 1720792881 54 M 1720 90 EM
TAYLOR MO,THOMAS L, 8901 W 74TH STE 34, 66204 362-9444 1902661031 40 M 1902 67 GS	WIGGINTON O O,GERALD O, 8800 W 75TH ST #220, 66204 384-5500 2878700051 44 M 2878 73 PD
TENNY MD,ROBERT T, 9119 W 74TH STE 303, 66204 432-1100 1902761361 51 M 1902 81 NS	WILEY MO,JOHN H, 9119 W 74TH STE 268, 66204 831-2334 4113631151 37 M 4113 70 OBG
THOMAS MO,MARTY H, 10600 QUIVIRA STE 320, 66215 541-3200 1902790931 51 F 1902 84 OBG	WILLIAMS MO,THOMAS A, 10550 QUIVIRA STE 220, 66215 894-4111 1902620920 36 M 1902 63 FP
THOMPSON MO,MICHAEL F, 10550 QUIVIRA, 66215 541-0577 3005791323 53 M 3005 89 GE	WILSON MO,ROBERT B, 6117 W 119TH APT 3318, 66209 1902400601 10 M 1902 40 00
THOMSEN MO,GARY, 9119 W 74TH STE 150, 66204 362-5510 3005762722 51 M 3005 77 FP	WILSON MO,SLOAN J, 5618 W 62ND, 66202 1902360618 10 M 1902 36 00
TOALSON MO,WILLIAM B, 8901 W 74TH STE 21, 66204 722-0080 1902630836 37 M 1902 64 CD	WOOD MO,FRED M, 8901 W 74TH STE 225, 66204 831-2604 4706620589 38 M 4706 80 ORS
TOMASKO MD,MARILYN A, 5300 W 94TH TERR, 66207 381-4674 55 F 4102 90 A	WURSTER MO,G. RICHARD, 3700 W 83RD STE 203, 66208 649-0923 1902610908 35 M 1902 62 P

YAUSSI MD,MARGARET H, 9119 W 75TH ST STE 300, 66204
677-1500 1902832005
56 F 1902 85 OBG

YEOMANS MD,RONALO N, 4401 W 109TH, 66211
345-1400 1902670986
40 M 1902 68 OBG

YOHE MD,RUTH M, 8600 W 95TH, 66212
383-3377 4107540437
26 F 4107 59 PDA

YOUNG MO,JOHN W, 9119 W 74 #306, 66204
383-1550 4706630401
37 M 4706 72 PS

YOUNGLOVE MO,HAL, 10550 QUIVIRA, 66215
341-0990 3005752379
50 M 3005 89 OBG

YUT JR MO,JOSEPH P, PO BOX 29194, 66201
676-2310 1602831058
57 M 1602 85 OR

ZACK MD,ASHLEY S, 4601 WEST 109TH STE 122, 66211
491-4045 2803731031
46 M 2803 74 PD

ZAMIEROWSKI MO,DAVID S, 8800 W 75TH STE 340, 66204
831-4113 2307680958
42 M 2307 78 PS

SMITH CENTER — 913
(Central Kansas Medical Society)

BARNES MO,JOE L, 119 E PARLIAMENT, 66967
282-6834 1902820082
54 M 1902 89 FP

CONANT MO,FERRILL R, 119 E PARLIAMENT, 66967
282-6834 1902860343
56 M 1902 GP

SHEPPARO MD,ROBERT G, 400 W COURT, 66967
1902450625
21 M 1902 45 00

SOUTH HAVEN — 316
(Cowley County Medical Society)

UBELAKER MD,ERNEST J, , 67140
892-2261 1902380597
11 M 1902 38 FP

ST. FRANCIS — 913
(Northwest Kansas Medical Society)

ALTER MD,BRUCE R, 221 W FIRST, 67756
332-2133 64927820020
43 M 3607 FP

CRAM MO,ERNEST R, PO BOX 625, 67756
332-2126 1902520178
24 M 1902 52 FP

STEPHENSON MD,LUCILLE C, 80X 824, 67756
1902320438
06 F 1902 32 00

STAFFORD — 316
(Ninnescah Medical Society)

BROWN MD,C EVERETT, PO BOX E, 67578
1902470103
10 M 1902 47 00

FARMER III D.O., F J, PO BOX 309, 67578
234-6826 2878790688
52 M 2878 80 FP

QUIJANO JR MO,RAMON S, 412 E GRAND, 67578
234-5236 74811710559
45 M 74811 83 GP

STERLING — 316
(Rice County Medical Society)

DYSART MD,JACK C, 224 N FOURTH, 67579
1601390201
12 M 3901 41 00

SIMPSON MD,TOM C, 239 N BROAOWAY, 67579
278-2123 1902731071
47 M 1902 74 FP

STILLWELL — 913
(Johnson County Medical Society)

ARMBRUSTER MD,ALBERT A, 3540 W 199, 66085
512550045
17 M 512 58 00

STOCKTON — 913
(Central Kansas Medical Society)

MAUCK MO,HAROLD C, 623 SOUTH 2ND, 67669
425-6280 1902540616
20 M 1902 54 FP

VOTAPKA MO,WILLIAM L, 623 S SECOND, 67669
425-6280 1902530904
24 M 1902 53 FP

SYRACUSE — 316
(Southwest Kansas Medical Society)

PARKS MO,DOUGLAS S, PO BOX 1131, 67878
384-5731 1902842159
56 M 1902 84 FP

PETTERSON MO,CECIL E, PROFESSIONAL ASSN BOX 1045, 67878
384-5731 1902390436
14 M 1902 39 FP

TONGANOXIE — 913
(Douglas County Medical Society)

STEVENS MD,PHILIP L, BOX 319, 66086
845-2090 1902540918
27 M 1902 54 FP

TOPEKA — 913
(Shawnee County Medical Society)

ALLEN MD,JAMES E, 2947 SW WANNAMAKER OR, 66614
273-2552 1902720037
46 M 1902 73 IM

ALLEN MD,TIMOTHY E, 823 MULVANE, 66606
234-3451 1902761817
49 M 1902 79 R

ARJUNAN MD, K N, 634 SW MULVANE ST #2D2, 66606
232-3555 4951470051
44 M 49568 83 NS

ARTZER MO, OENNIS C, 9D1 GARFIELD, 66606
354-9591 190276DD55
51 M 1902 NEP

ARUNAKUL MD, PUNYA, 1710 W TENTH, 666D4
234-2624 89102690622
44 M 89104 8D OTO

ASHLEY JR MD, 8 JDHN, 1616 WEST 8TH ST, 66606
233-2280 19D2560048
31 M 1902 56 OPH

ASHLEY MO, BYRON J, 3222 PLASS, 66611
233-2280 190224D019
98 M 1902 24 OPH

ASHLEY MO, THOMAS J, 1616 W 8TH, 66606
233-2280 1902840083
58 M 1902 88 OPH

ATWODD MD, MICHAEL D., 901 GARFIELD, 66606
232-9394 1902820040
56 M 1902 84 FP

AVERILL MD, STUART C, MENNINGER FO 80X 829, 66601
273-750D 502520041
24 M 502 58 P

BAIR MD, GLENN O, 23DD SW 29TH #123, 66611
267-3025 2401570066
31 M 2401 59 IM

BAKER MD, PHILLIP L, 909 MULVANE, 66606
357-D301 3005630061
37 M 3005 63 ORS

BAKER MD, RAY O, 4430 MARLBORD RD, 66610
4812550051
3D M 4812 67 00

BARABAN MD, MARC R, 823 MULVANE STE 200, 66606
357-5325 2846750030
50 M 2846 80 PS

BARNETT MD, ROBERT E, 823 MULVANE STE 280, 66606
235-0202 28D2820031
00 M 28D2 84 OBG

BASSETT MO, PAUL M, 1500 SW 10TH, 66604
354-6100 1902770077
52 M 19D2 80 EM

BAUM MO, CURTIS A, 823 MULVANE, 666D6
345-9591 1902830193
57 M 1902 84 IM

BEALE MD, OAVID A, MENNINGER BDX 829, 66601
273-7500 5404560028
31 M 5404 64 P

BECK MD, JOSEPH O, 2760 SW BURLINGAME RO, 66611
30D5430118
18 M 3005 47 00

BEOFORO MO, O R, PO 80X 4927, 66604
4802400140
D9 M 4802 46 00

BEELMAN MO, FLOYD C, 1286 LAKESIDE DR, 66604
384D350079
02 M 3840 36 FP

BELLER MO, WILLIS L, 63 SW PEPPER TREE LN, 66611
1902410046
14 M 1902 41 00

BELLOWS-BLAKELY MD, DAVID S, BOX 829, 66601
273-750D 190277D123
51 M 1902 P

BLEIBERG MD, EFRAIN, PO BOX 829, 66601
273-7500 64902760057
51 M 6493D 78 P

BONEBRAKE MO, C RICHARD, 634 MULVANE STE 104, 66606
295-5330 160675D184
48 M 1606 79 OBG

BDREL MD, OAVID, 1700 W 7TH PATH DEPT, 66606
295-8473 19D271D104
45 M 1902 72 PATH

BDRGE MD, CARLOS A, 823 MULVANE #275, 66606
233-7138 64903770064
54 M 64914 88 P

BOWEN JR MO, HARRY J, 1900 SW PEMBROOK LN, 66604
1902370087
11 M 19D2 37 00

BOWEN MD, CLDVIS W, 2200 WEST 10TH, 66604
234-86D1 1902370079
12 M 1902 37 FP

BOWEN MO, JUOITH M, MENNINGER 80X 829, 66601
273-7500 4720820035
55 F 4720 84 P

BOYER MD, DEBDRAH A, 634 SW MULVANE STE 305, 66606
232-6633 3006830101
58 F 3006 89 AN

BRAHMAN MO, HERBERT O, 1700 SEVENTH, 66606
295-8471 512700039
43 M 512 79 PATH

BRAUN MD, ROBERT W, 823 MULVANE 4TH FL, 66606
354-9591 28D3700063
44 M 28D3 76 IM

BRIOWELL MD, RUSSELL E, 4715 W CEDAR CREST, 66604
1902510075
26 M 1902 51 00

BRODSKY MO, TRINA A, 634 MULVANE STE 104, 66606
295-5330 1401840415
53 F 1401 08G

BRUNER JR MO, KENNETH W, 1125 GAGE STE 8, 66604
271-6164 2401701373
44 M 2401 74 PATH

CACHIA MO, RICHARD M, 1700 W 7TH PATH DEPT, 66606
295-8472 62701730017
51 M 62701 78 PATH

CASHMAN JR MO, MAURICE R, 823 MULVANE STE 400, 66606
354-9591 1902610151
35 M 1902 66 HEM

CHALLA MO, SHEKHAR K, 2200 SW 6TH #104, 66606
354-8518 49557790062
56 M 49521 87 GE

CHEN MD, CHU-CHI, CTRL UROLOGY 1710 W 10TH #200, 66604
354-4465 24405730037
47 M 24405 81 U

CHEN MO, TAK-MING, 823 SW MULVANE #230, 66606
234-3451 24405680161
41 M 24402 76 AN

CHERRY JR MO, ARTHUR C, 1125 SW GAGE, 66604
273-9813 3806530114
27 M 3806 58 PD

CLARK MD, CRAIG N, 300 SE NORWOOD, 66607
1902580197
29 M 1902 58 00

COCHRAN MO, PAUL W, MENNINGER BOX 829, 66601
273-7500 4802580229
33 M 4802 76 IM

COHEN MD, LOUIS, 823 MULVANE, 66606
233-7175 1902410101
14 M 1902 41 IM

COKER MO, W LAURENCE, 901 SW GARFIELD AVE, 66606
354-0570 1902780366
53 M 1902 81 FP

COLLINS MD, DEAN T, MENNINGER FO 80X 829, 666D1
273-7500 1902550239
28 M 1902 55 P

COLLINS MD, EDWARD J, 9D0 WASHBURN, 66606
233-3242 1611710344
45 M 1611 77 OPH

CONOVER MO, MARGARET A, 634 MULVANE #305, 66606
232-6633 3006840191
58 F 3006 89 AN

CONROW MD, JEFFREY K, 823 MULVANE, 66606
354-9591 1902770328
52 M 1902 IM

CONROY MD,ROBERT W, MENNINGER FD 80X 829, 66601
273-7500 2604640281
38 M 26D4 71 P

COOLEY MD,DENNIS M, 1125 SW GAGE B, 66604
273-9813 1902770336
51 M 1902 79 PD

CODN MD,STEPHEN D, 1 MEO PK W 8LOG 823 MULVANE, 66606
234-3451 190283D479
56 M 1902 85 RD

COPPLE JR MD,HAL E, 4100 SW 15TH ST, 66604
273-8224 3005780232
46 M 3005 84 PNP

COTTON MD,ROBERT T, 7520 OXFORDSHIRE RD, 66614
190245D161
19 M 1902 45 OD

CRARY MD,JOHN E, 300 WOODLAWN, 66606
190243025D
18 M 1902 43 00

CROUCH MD,STEVEN W, 4100 SW 15TH ST, 66604
273-8224 1902760365
51 M 1902 77 PO

CROUCH MD,WILLIAM H, 2101 SW 31ST TERR, 66611
28D2450217
20 M 2802 51 QO

CURTIS MD,JEFFERY L, 9D1 GARFIELD, 66606
354-9591 19D2810192
55 M 1902 82 IM

DAMMON JR MD,JAMES W, 833 GARFIELD, 66606
233-1690 4812820422
56 M 4812 89 COTS

DATTILD MD,RAYMONO, 634 MULVANE STE 203, 66606
233-9343 5500282D110
55 M 55002 88 CD

DAUGHETY MD,TEO W, 901 GARFIELD, 66606
354-9591 4812740267
49 M 4812 86 IM

DAVIS MD,CHESTER R, 1710 SW 10TH AVE #101, 66604
232-6020 19D2751889
50 M 1902 76 FP

DELGADO MD,SERGIO, 634 MULVANE STE 20D, 66606
357-0352 25D1620389
37 M 2501 74 ORS

DELGADO MD,SERGIO VICTOR, MENNINGER 80X 829, 66601
273-750D 649D2810D11
57 M 64902 82 P

DONEPUDI MD,RAO S, 634 MULVANE STE 305, 66606
232-6633 49550740132
49 M 49550 82 AN

DUNAGIN MD,JACK A, 153D STRATFORD RD, 66604
1902440433
2D M 1902 44 00

DUNIVEN MD,PHILIP L, 1 MED PK W BLDG 823 MULVANE, 66606
234-3451 481277D425
52 M 4812 81 R

DURST JR MD,ROBERT D, 17D6 SW TENTH, 66604
357-5166 2803690980
42 M 2803 72 D

EATON MD,EDWARD L, 823 MULVANE STE 275, 66606
233-7138 401721134
40 M 401 73 P

ELDER MD,D MIKEL, 1 MED PK W BLDG 823 MULVANE, 666D6
234-3451 19D2690294
41 M 1902 73 DR

FAIRCHILLO MD,RICHARD S, 901 GARFIELD, 66606
354-9591 1902742120
48 M 1902 END

FEAGAN MD,JERRY, 2200 SW 6TH, 66606
233-3555 1902630216
39 M 1902 64 GE

FEIFAREK MD,MICHAEL J, 900 SW WASHBURN, 66606
235-3322 560582D338
50 M 5605 OPH

FERNANDEZ MD,LUIS A, 2707 WEST 13TH, 66604
27501410751
14 M 27501 68 00

FIELD MD,RICHARD A, 823 SW MULVANE #230, 66606
235-3451 1902550387
29 M 1902 55 AN

FIELO-KRESIE MD,DEBBIE A, 8TH & LINCOLN, 66606
233-5101 1902850488
59 F 1902 88 OBG

FITZGERALD MD,DAVID A, 901 GARFIELD, 66606
357-6171 1205700141
41 M 1205 88 N

FOSTER MD,O BERNARD, 900 SW 31ST STE 316, 66611
2501380264
14 M 2501 47 00

FRANKLIN JR MD,8ENJAMIN A, 1 MEO PK W 8LDG 823 MULVANE, 66606
234-3451 1902760497
45 M 1902 77 R

FREUNO MD,WILLIAM L, 901 GARFIELD, 666D6
354-9591
54 M 1902 CO

GA88ARO MD,GLEN O, PO BOX 829, 66601
273-7500 1601750950
49 M 1601 76 P

GANOHI MD,SHANTIKUMAR K, 833 GARFIELD, 66606
233-1690 49501650250
40 M 49501 78 TS

GANZARAIN MD,RAMON C, 2521 SW COLLEGE, 66611
354-8007 23101470075
23 M 23101 73 P

GARDNER MD,J DOUGLAS, 901 GARFIELD, 66606
354-9591 190276D501
51 M 1902 78 RHU

GAY MD,JOHN D, 1 MED PK W 8LOG 823 MULVANE, 66606
234-3451 4802680452
42 M 4802 74 OR

GEIS MD,OICK A, 901 GARFIELD, 66606
354-9591 1902730407
47 M 1902 84 OM

GEIST MD,MICHAEL J, 9544 SW 45 ST, 66610
478-4344 1902850858
58 M 1902 GP

GENOEL MD,JOSEPH E, PO BOX 4127, 66604
235-9914 4804370205
12 M 4804 52 DRS

GIESSEL MD,MICHAEL D, 823 MULVANE 4TH FL, 66606
354-9591 1902740364
48 M 19D2 74 D

GIMPLE MD,KENNETH, 631 HORNE STE 200, 66606
233-7491 1902710406
45 M 1902 78 ORS

GIROUX MD,GUY M, 1700 W 7TH, 66606
295-80D0 300684D336
57 M 3006 AN

GLEASON MD,JIMMIE A, 80D LINCOLN, 66606
233-51D1 1902580332
33 M 1902 6D OBG

GRAY MD,DAVIO E, 1208 SW 29 TER #A-5, 66611
1606420516
16 M 1606 42 DD

GRAYIB MD,ANTOINE S, 1625 OAKLEY, 66604
60501460D55
18 M 60501 58 00

GREENBERG MD,MARK, 1 MED PK W BLDG 823 MULVANE, 666D6
234-3451 1611720633
46 M 1611 76 R

GREENE MD,HORACE T, 156 SW FAIRLAWN RD, 66606
4D1420258
15 M 401 47 00

GREENE MD,RUSSELL E, 1 MEO PK W BLDG 823 MULVANE, 666D6
234-3451 51579D187
53 M 515 83 RT

GREER MO,RICHARD H, 1207 W 29TH A-7, 66611

1902390193
09 M 1902 39 00

GUTOVITZ MO,ALLEN LOUIS, 634 MULVANE STE 203, 66606

233-9643 1611720668
46 M 1611 79 CO

HACKER MO,ELAINE MARY, 3026 QUAIL CREEK, 66614

296-3981 2604500250
25 F 2604 78 OBG

HALL MO,ROY P, 634 MULVANE STE 402, 66606

295-5310 5107850432
59 M 5107 88 FP

HALLEY MO,M MARTIN, 901 GARFIELD, 66606

233-1710 2401530579
27 M 2401 59 TS

HAMILTON JR MD,JAMES J, 823 MULVANE STE 220, 66606

234-3451 1902810346
55 M 1902 87 GPVS

HANSEN MO,ERIC E, 1504 SW 8TH ST, 66606

235-6600 64935840242
51 M 64935 90 PM

HARRIS MO,HUBERT L, 1001 HORNE STE 210, 66604

233-3151 1803390301
12 M 1803 49 0

HARRIS MO,PATRICIA A, 1617 W 26TH, 66611

1902540446
29 F 1902 54 00

HARRISON MO,HALL E, 901 GARFIELD, 66606

354-9591 2802650313
39 M 2802 72 IM

HARVEY MO,R CLAY, 1 MEO PK W BLOG 823 MULVANE, 66606

234-3451 1902780773
52 M 1902 79 R

HEBBAR MO,SATYA N, 634 MULVANE STE 203, 66606

233-9643 49509630240
39 M 49509 74 CO

HEDEGAARD MO,CHERYL K, 634 MULVANE #104, 66606

295-5330 3005830574
46 F 3005 87 OBG

HEEB MO,CAMILLE S., 1125 SW GAGE, 66604

273-9813 1902790841
44 F 1902 83 PO

HILL MD,ROBERT N, 901 GARFIELD, 66606

354-9591 1902670391
14 M 1902 68 IM

HIRSCHBERG MO,J COTTER, MENNINGER BOX 829, 66601

273-7500 1602400103
15 M 1602 52 CHP

HISZCZYNSKYJ MO,ROMAN, 1500 W TENTH, 66604

354-6031 1803660472
35 M 1803 70 PATH

HOBBS MD,DONALD O, 2858 PLASS, 66616

2401540582
28 M 2401 63 00

HOLMES MO,ROBERT W, 901 GARFIELD, 66606

354-9591 1902770662
52 M 1902 80 IM

HOSTETTER MD, M MORGAN, 800 SW LINCOLN, 66606

233-5101 1902691215
46 F 1902 74 OBG

HOSTETTER MO,JAMES P, 3921 SW CHELMSFORD RD, 66610

1902690570
43 M 1902 70 EM

HOYT MO,ARTHUR W, 2521 NW 35TH, 66618

234-5663 2501400559
14 M 2501 55 P

HSU MO,CHENG H, 1516 W SIXTH, 66606

232-1005 38504660173
41 M 38502 74 U

HSU MO,SHIN-FU, 1001 GARFIELD #203, 66604

232-0362 24402680209
43 M 24402 0TO

HUANG MO,JONSON, 901 GARFIELD, 66606

357-6171 2701770474
52 M 2701 81 N

HUSTON MO,JOSEPH W, 634 MULVANE #200, 66606

357-0352 1902620393
35 M 1902 63 ORS

HUTTON MO,FREDERICK A, 1001 GARFIELD STE 102, 66604

234-0553 6701580417
29 M 6701 66 PS

HYLANO MO,JOSEPH M, MENNINGER BOX 829, 66601

273-7500 53902680591
45 M 53902 74 P

ILIFF MO,R DOUGLAS, 1119 GAGE, 66604

271-6161 1902742260
49 M 1902 80 FP

ILORETA MD,ALFREDO T, 1516 W SIXTH, 66606

232-1005 74801710429
47 M 74801 80 U

ISAACSON MO,RICHARD N, 1001 GARFIELD STE 301, 66604

233-4256 2501750975
48 M 2501 80 U

JACKSON JR MO,DONALD H, 634 MULVANE #203, 66606

233-9643 3515690424
40 M 3515 84 CO

JACOBY II MO,ROBERT E, 901 SW GARFIELD AVE, 66606

354-0570 2307720461
46 M 2307 75 FP

JANSSSEN MO,ERWIN T, MENNINGER BOX 829, 66601

273-7500 1803620551
36 M 1803 70 P

JENSEN MO,ROBERT O, 1500 W TENTH, 66604

354-6031 3005790653
53 M 3005 83 PATH

JONES MO,CLIFTON C, 823 MULVANE, 66606

354-9591 1902810460
55 M 1902 80 IO

JOSEPH MO,BRIAN W, 823 MULVANE STE 275, 66606

233-7138 35205610012
38 M 35205 74 CHP

JOSS MO,CHARLES S, 1400 STRATFORD, 66604

1606400612
14 M 1606 40 00

JOYCE MO,G BERNARD, 4929 WEST HILLS OR, 66606

233-7491 1902440808
17 M 1902 44 ORS

KATZ MO,DANIEL A, PO BOX 829, 66601

273-7500
52 M 4802 PON

KATZ MO,JEROME B, BOX 829, 66601

273-7500 2101441175
22 M 2101 52 P

KAVEL MD,KARL K, 1123 SW GAGE, 66604

273-9999 3605640248
36 M 3605 72 POA

KEARNS MO,NORBERT W, MENNINGER BOX 829, 66601

273-7500 1002701142
43 M 1002 72 P

KELLY MO,DAN A, 4100 SW 15TH ST, 66604

273-8224 2803640265
39 M 2803 69 PO

KENNEEY MO,JENNIFER E, PO BOX 829, 66601

273-7500
57 F 4813 86 P

KEYS JR MO,ROBERT C, 823 SW MULVANE #230, 66606

235-3451 1902620431
36 M 1902 64 AN

KIM MO,YONG W, 631 HORNE STE 110, 66606

232-6964 58302490013
28 M 58302 61 IM

KINOLING MO,PAUL H, 901 GARFIELD, 66606

233-1710 3545610417
30 M 3545 68 TS

KIRKEGAARD MD,RODGER S, 22D5 SW ARYONIA PL, 66614
18D3560451
30 M 1803 64 00
KLEINHOLZ JR MD,EMIL JOHN, 634 MULVANE #201, 66606
232-1227 3503650320
39 M 3503 79 IM
KLEMMER MD,HERBERT, 1259 SW PEM8ROKE LN, 66604
273-7500 4102370517
11 M 4102 56 P
KNAPPENBERGER MD,KURT R, 631 HORNE STE 20D, 66606
233-7491 19D2800651
54 M 1902 88 ORS
KNIGSBERG JR MO,CHARLES, 3450 SW BRANOWY WINE CT, 66614
4706651425
4D M 4706 88 PH
KOONTZ MD,JUOITH A, BOX 829, 66601
233-5033 1902750823
49 F 1902 81 CHP
KOOSER MO,JUDITH A, 1 MED PK W BLDG 823 MULVANE, 66606
234-3451 1601810308
47 F 1601 85 TR
KOSSOY O O,ALLEN F, 901 GARFIELD, 66606
354-9591 2878810344
53 M 2878 A
KOVARIK MD,ERNEST D, 620 SE MADISON STE 154, 66607
233-180D 3005640317
36 M 3005 71 OPH
KDWALSKI MD,PETER C, 1351 SW CAMP8ELL, 66604
273-7500 3901830877
57 M 3901 84 P
KOWALSKI MD,STEPHEN F, 1417 SW MACVICAR, 66604
273-7500 3901810876
55 M 3901 83 P
KRESIE MO,RANOALL J, 631 HORNE STE 130, 66606
233-0011 19D2841055
58 M 1902 88 OPH
KRDLL MD,HARRY G, 2912 CEOAR COVE CT, 66614
1602500337
24 M 1602 57 00
LACCHEO MO,MICHAEL L, 1119 GAGE, 66604
271-6000 3840761192
51 M 3840 82 FP
LAI MD,MAX G, 1710 W 10TH #200, 66604
354-4465 24405720031
45 M 24405 81 U
LANG MD,CLAYTON A, 634 SW MULVANE STE 305, 66606
232-6633 1902650497
39 M 1902 88 AN
LAUNEY MD,WALTON S, 1 MED PK W BLDG 823 MULVANE, 66606
234-3451 4804752094
39 M 4804 81 R
LEE MO,SDNG OOW, 823 SW MULVANE #230, 66606
235-3451 24405680137
43 M 38505 74 AN
LEE MO,SONG PING, 823 MULVANE STE 250, 666D6
233-6001 38502610462
34 M 38502 74 OTO
LEIFER MD,WILLIAM N, 15D0 W TENTH, 66604
354-6031 1902730652
47 M 1902 78 PATH
LEIKER MD,JOSEPH, 1133 TOPEKA BLVD, 66610
291-8448 19D2740674
48 M 1902 IM
LENTZ MD,WILLIAM R, 2930 SW WANAMAKER OR STE 5, 66614
272-2332 1902530548
24 M 1902 53 FP
LEPSE MD,PETER S, 909 MULVANE, 666D6
357-0301 18D3800932
57 M 1803 ORS
LESSENDEN JR MD,C M, 5635 NW BRICKYARO RO, 66618
272-3111 19D2430454
18 M 1902 43 D
LEVY MD,EDWIN Z, 4125 SW GAGE L-6 PO 8DX 4311, 66604
273-561D 1606540783
29 M 1606 59 P
LIESMANN MD,JEAN E, 901 GARFIELD, 66606
354-9591 19D2742286
49 F 1902 77 IM
LISTERMAN MD,JOHN C, 8C/BS PO 80X 239, 66629
291-8221 28D3741D45
42 M 28D3 83 FP
LOGAN MD,WILLIAM S, PD BOX 829, 66601
273-7500 4812771596
49 M 4812 84 P
LUI MD,NASON, 1516 W SIXTH, 66606
233-1747 1606770819
48 M 1606 83 GPVS
LYNCH MO,JOHN A, 909 MULVANE, 66606
357-D3D1 2834550591
30 M 2834 64 ORS
MARPLES MO,BRADLEY W, 901 GARFIELD, 66606
354-9591 1902831131
56 M 1902 86 IM
MARTIN MO,WILLIAM O, 3643 YORKWAY, 66604
1902440956
19 M 1902 44 00
MARTINAK MD,JOSEPH F, PO BOX 239, 66629
291-8711
39 M 3506 89 FP
MCCARTER MO,DUANE K, 2101 W 10TH, 66604
233-8979 1902580600
26 M 1902 65 IM
MCCARTHY MD,AILEEN C, 901 GARFIELD, 66606
354-9591 19D2831173
57 F 1902 IM
MCCOMAS JR MD,MARMADUKE O, 3020 BRUSH CREEK CR, 66614
1902430501
16 M 19D2 43 U
MCCDY MO,MICHAEL T, 823 MULVANE #370, 66606
233-0117 1902752389
49 M 19D2 80 ORS
MCELRDY MD,RDBERT T, 823 MULVANE STE 220, 66606
232-0444 1902610568
35 M 1902 62 GS
MCKINNEY D O,SHARDN L, 631 HDRNE STE 31D, 66606
354-1299 2878830124
41 F 2878 PM
MEIDINGER MD,RICHARD, 1 MED PK W BLDG 823 MULVANE, 66606
295-8011 19D2650594
39 M 1902 66 DR
MENNINGER MD,ROBERT G, MENNINGER FD BOX 829, 66601
232-7214 3545520493
22 M 3545 53 P
MENNINGER MD,RDY W, BOX 829, 66601
273-7500 3520510515
26 M 352D 62 P
MENNINGER MD,W WALTER, MENNINGER FD BOX 829, 66601
273-7500 352D570526
31 M 3520 59 P
MEYER MD,D WARREN, 634 MULVANE #203, 66606
233-9643 1902742189
49 M 1902 80 CO
MHATRE MD,VIJAY R, 620 SE MADISON PO 80X 1979, 66601
232-4566 49528740111
49 M 49528 84 IM
MILLS JR MD,PHILIP E, 9D1 GARFIELD, 66606
357-6171 1902640637
36 M 19D2 65 N
MISKE MD,STEPHAINE A, 823 MULVANE, 66606
234-3451 3005821001
56 F 3005 83 DR
MODLIN MO,HERBERT C, MENNINGER FO BOX 829, 66601
273-7500 300538D366
13 M 3005 50 P

MDRRIS MO, MERLE O, 2800 MAC VICAR, 66611 1902450455 21 M 1902 45 DO	PAYNE MO, ROBERT R, 631 HORNE STE 200, 66606 233-7491 1902550891 29 M 1902 55 ORS
MORRISON MD, GRACE A, 800 SW LINCOLN, 66606 233-5105 1902800871 48 F 1902 81 OBG	PENZLER MO, CINOY E, 631 HORNE STE 130, 66606 233-0011 1902850429 59 F 1902 89 OPH
MORRISON MO, MICHAEL R, 800 LINCOLN, 66606 233-5101 1902760985 50 M 1902 78 OBG	PERQUE II MO, W LANG, 631 HORNE STE 400, 66606 354-9504 1902742197 49 M 1902 81 GS
MUELLER MO, ARNOLD V, 901 GARFIELD, 66606 354-9591 3005570441 31 M 3005 58 IM	PETERSON MO, ROBERT L, 1500 W 10TH, 66604 354-6000 1902620679 36 M 1902 63 EM
MURPHY MO, MICHAEL, 9D1 SW GARFIELDO AVE, 66606 354-0570 3005830957 57 M 3005 89 FP	PETERSON MO, VERNON J, 1 MEO PK W 8LOG 823 MULVANE, 66606 234-3451 512680542 42 M 512 73 R
MYERS IV MO, PERCY C, 634 MULVANE STE 305, 66606 232-6633 1902750866 46 M 1902 AN	PETRIK MD, EDWIN L, 823 MULVANE 4TH FL, 66606 354-9591 1902640718 35 M 1902 65 IM
MYERS MO, JO ANN, MENNINGER 80X 829, 66601 273-7500 1902530602 28 F 1902 53 P	PETTERSON MD, OENNIS CRAIG, 1 MED PK W 8LOG 823 MULVANE, 66606 234-3451 1902741981 49 M 1902 76 R
NABOURS MO, RICHARD D, 4228 W 29TH ST TERR, 66614 272-7190 1902541043 27 M 1902 54 FP	PFUETZE MD, ROBERT E, 1800 WESTWOOD OR, 66604 232-3332 1902350337 09 M 1902 35 OBG
NATHAN MO, WILLIAM A, MENNINGER BOX 829, 66601 273-7500 3503720468 48 M 3503 CHP	PIERCE MO, CHARLES F, 4108 SW EMLAND OR #3, 66606 410151D862 24 M 4101 55 00
NICE MD, G WILLIAM, 915 BUCHANAN, 66606 19D2460434 22 M 1902 46 00	PIERCE MO, DONALO R, 5035 SW 23RD, 66614 5101490329 23 M 5101 50 00
NDRTHWAY MO, DANIEL P, 823 MULVANE STE 275, 66606 233-7138 1102740838 42 M 1102 P	POLLY MO, RICHARD E, 909 MULVANE, 66606 357-0301 1803680899 42 M 1803 75 ORS
NOVOTNY MD, PETER C, MENNINGER FO BOX 829, 66601 273-7500 15407550029 30 M 15407 63 P	PORTER MO, ROBERT O, 9D1 GARFIELDO, 66606 354-9591 2802670527 41 M 2802 73 IM
O'CALLAGHAN MO, WILLIAM K, 901 GARFIELD, 66606 354-9591 1002710834 45 M 1002 77 IM	POULTON MO, THOMAS J, 634 MULVANE STE 305, 66606 232-6633 384D751707 50 M 3840 AN
O'NEIL MO, ROBERT H, 901 GARFIELD, 66606 354-9591 1902450544 20 M 1902 45 IM	PDWELL II MD, BENSON M, 631 HORNE STE 400, 66606 354-9504 1606490743 26 M 1606 55 TS
DBOURN MD, ROBERT L, 1150 OAKLEY, 66604 28D2500541 19 M 2802 51 00	POWELL MO, WILLIAM R, 2778 SW MACVICAR AVE, 66611 233-8941 1902540756 30 M 1902 54 GS
OWEN III MO, JAMES W, 1 MED PK W 8LDG 823 MULVANE, 66606 234-3451 2802790778 54 M 2802 83 DR	PRESTON MO, RALPH R, 5025 BRENTWOOD RD, 66606 1902441243 19 M 1902 44 00
PALMBERG MO, KENT E, 901 GARFIELDO, 66606 354-9591 1902742481 49 M 1902 76 IM	PROKOP MO, BRAOFORO S, 920 SW WASHBURN, 66606 233-3900 1606570909 32 M 1606 61 OPH
PARMAN MD, ROBERT D, 3020 W 21ST, 66604 19025407D5 27 M 1902 54 00	RAINBOW-EARHART MD, KATHRYN A, 2916 KENTUCKY, 66605 4707480446 21 F 4707 63 00
PARR JR MO, HAROLD E, 4100 SW 15TH, 66604 273-8224 1902821470 51 M 1902 PD	RAJU MO, A S PADMA, 1710 W 10TH STE 208, 66604 234-3211 49509610052 39 M 49509 81 TS
PARULKAR MO, DEEPAK S, 823 MULVANE #230, 66606 235-3451 49517720100 49 M 49517 77 AN	RAMSEY MD, BARTLETT W, 4100 SW 15TH, 66604 273-8224 1902500576 25 M 1902 50 PO
PASCUA MD, PERCIVAL G, BOX 829, 66601 273-7500 74808621537 39 M 74808 80 IM	RANOALL MD, GORDON R, 1 MEO PK W 8LOG 823 MULVANE, 66606 234-3451 4706781833 50 M 4706 83 R
PATEL MD, MAHENDRA N, 62D MAOISON, 66607 232-424B 91708740042 48 M 91708 IM	RANDELL MO, EOGAR C, 800 LINCOLN, 66606 233-5101 3005660598 41 M 3005 71 OBG
PATEL MO, VINOD, 620 SE MAOISON STE 301, 66607 232-1880 49531700031 47 M 49531 74 N	RANSOM MD, JAMES H, 1123 SW GAGE, 66604 273-9999 1803620829 36 M 1803 67 A
PATRICK MD, FRED EDWARD, 4100 SW 15TH ST, 66604 273-8224 19D271084B 45 M 1902 72 PD	REINKING MD, VICTOR E, 631 HORNE STE 110, 66606 233-5084 1902520526 26 M 1902 52 IM

REYMONO MO,RALPH O, 1 MED PK W 8LDG 823 MULVANE, 66606 295-8008 2301670853 37 M 2301 72 R	SEHOEV MO,JOAN, 631 HORNE STE 310, 66606 233-3553 6101630275 40 F 6101 74 FP
RHOAOS MO,JAMES P, 419 W 29TH PO 80X 110, 66601 291-7084 3520600671 34 M 3520 67 IM	SELLERS MO,JEFF O, 823 MULVANE STE 230, 66606 235-3451 1902860001 55 M 1902 90 AN
RHOAOS MD,JEFFREY P, 823 MULVANE 4TH FL, 66606 354-9591 1902841519 56 M 1902 85 IM	SHEAFOR MD,DOUGLAS, 823 MULVANE STE 275, 66606 233-7138 1902600775 34 M 1902 61 P
RICCI MO,ROBERT LAWLER, 823 MULVANE STE 400, 66606 354-9591 1902752656 50 M 1902 76 IM	SHEEHY MD,PATRICK G, 901 GARFIELD, 66606 354-9591 5605801279 54 M 5605 86 CD
ROBERTS MO,WARREN E, PO 80X 4047, 66604 272-5797 1902570728 25 M 1902 57 FP	SHELTON MO,STEPHEN E, 823 MULVANE STE 275, 66606 233-7138 702610591 35 M 702 67 P
ROBINSON MO,DAVID R, 800 LINCOLN, 66606 233-5101 1902730954 47 M 1902 74 OBG	SHERWOOD JR MD,CLARENCE E, 3226 TIMBERLAKE LN, 66614 272-2928 702530547 22 M 702 62 GS
ROEDER MO,ROBERT E, 901 GARFIELD, 66606 354-9591 1902670846 40 M 1902 68 IM	SHEU MO,W ERIC, 823 SW MULVANE #230, 66606 235-3451 24350670072 43 M 38505 82 AN
ROSEN MD,ODNARD E, 5800 W 6TH, 66604 273-7500 1902842175 56 M 1902 88 P	SIMPSON MO,WILLIAM S, MENNINGER 80X 829, 66601 273-7500 6001480071 24 M 6001 63 P
ROSS MO,JACK L, MENNINGER 80X 829, 66601 273-7500 4812560781 32 M 4812 63 P	SISK MO,PHILLIP B, 1 MED PK W 8LDG 823 MULVANE, 66606 234-3451 1803560869 32 M 1803 64 R
ROBERT MD,LARRY, 1001 GARFIELD STE 301, 66604 233-4256 3005660636 38 M 3005 77 U	SLAUGHTER ,JERRY, 1300 TOPEKA, 66612 235-2383 00 M
ROY MD,WILLIAM R, 6137 SW 38TH TERRACE, 66610 1606490786 26 M 1606 54 00	SNARR MO,JACK W, 1 MED PK W 8LOG 823 MULVANE, 66606 234-3451 6201650311 41 M 6201 77 DR
RUPP MO,RICHARD J, 901 GARFIELD, 66606 354-9591 3841680722 42 M 3841 75 CO	SPANGLER MD,HENRY E, 901 GARFIELD, 66606 354-9591 3005821311 56 M 3005 86 IM
SANCHEZ MD,ROGELIO, 1516 W 6TH, 66606 232-1005 64901610531 31 M 64901 70 U	SPENCER MO,MILLARD C, 1 MED PK W 8LOG 823 MULVANE, 66606 234-3451 1902551073 28 M 1902 55 R
SARGENT MD,JOSEPH D, MENNINGER 80X 829, 66601 273-7500 2501581324 32 M 2501 66 IM	SPENCER MO,WAYNE E, 2200 SW 6TH, 66606 233-9686 1902640840 38 M 1902 65 GE
SAYLOR MD,EDWARD H, 634 SW MULVANE #410, 66606 273-9813 1902650799 39 M 1902 66 PD	STEIN MO,JOSEPH M, 901 GARFIELD, 66606 357-6171 3519471069 24 M 3519 56 N
SAYLOR MO,LESLIE L, 1945 HIGH, 66604 1606351115 07 M 1606 36 00	STOCK MO,KARL W, 2740 BURLINGAME RD, 66611 2834370975 13 M 2834 44 00
SAYLOR MD,MARK, 1710 SW 10TH #208, 66604 234-3211 1902660948 37 M 1902 67 GS	SUFI MO,M ASHRAF, 2200 SW 6TH #104, 66606 354-8518 70402680189 43 M 70402 77 GE
SAYLOR MD,STEPHEN, 901 SW GARFIELD AVE, 66606 232-9394 1902731039 47 M 1902 74 FP	SUFI MO,QAISER A, 7241 FOUNTAINDALE, 66614 354-8518 70402680294 44 F 70402 77 PATH
SCAMMAN MO,W WIKI, 2115 W 10TH, 66604 232-2322 4705570367 32 M 4705 64 PATH	SUNOBYE MD,KEVIN R, 901 GARFIELD, 66606 354-9591 1902831785 57 M 1902 89 IM
SCHLOESSER MD,HARVEY L, 1914 WARNER CT, 66604 3901510538 21 M 3901 55 00	SWOGGER JR MD,GLENN, MENNINGER 80X 829, 66601 273-7500 3806600724 35 M 3806 72 P
SCHLOESSER MO,PATRICIA T, 1914 WARNER CT, 66604 3901490405 24 F 3901 53 00	TAHERNIA MO,CYRUS, 1500 SW 10TH, 66604 354-5959 51701560446 32 M 51701 88 POC
SCHLOESSER MO,PETER E, 823 MULVANE, 66606 234-3451 1902831599 58 M 1902 87 DR	TAKAHASHI MO,TETSURO, PO 80X 829, 66601 273-7500 57203600145 32 M 57211 75 P
SCHMIDT MO,MICHAEL J, 631 HORNE STE 200, 66606 233-7491 1902791597 54 M 1902 84 ORS	TARGOWNIK MD,KARL K, 1218 W TENTH, 66604 40710490181 15 M 40710 59 00
SCHRAM MO,PETER CHARLES, PO BOX 829, 66601 273-7500 2507690826 39 M 2507 76 P	TARNOWER MO,WILLIAM, 2112 CREST DR, 66614 4802480721 21 M 4802 53 00

TEETER MD, SCOTT M, 1130 N KANSAS, 66608 233-0022 1902831807 57 M 1902 IM	WARRICK MD, DAVID ALAN, 620 SE MAOLSON PO BOX 1979, 66601 232-4566 3843760596 49 M 3843 79 IM
TEMPERO MD, STEPHEN J, 1 MED PK W BLDG 823 MULVANE, 66606 234-3451 1606671012 42 M 1606 72 R	WATKINS MD, STEVEN C, 901 GARFIELD, 66606 354-9591 1902741841 49 M 1902 76 END
THOMS MD, NORMAN W, 901 GARFIELD, 66606 233-1710 2501591605 34 M 2501 75 TS	WAUGH MD, CHARLES W, 823 MULVANE #230, 66606 235-3451 1902841900 57 M 1902 AN
THURSTON MD, DAVID E, 631 HORNE STE 200, 66606 233-7491 1902551138 29 M 1902 55 ORS	WEAVER MD, WALTER D, 900 WASHBURN ST, 66606 233-3636 1902691053 41 M 1902 70 OPH
TIETZE MD, OENNIS D, 634 MULVANE STE 402, 66606 295-5310 1902781826 50 M 1902 79 FP	WEBER II MD, RALPH H, HMO KS INC PO BOX 110 COST CTR, 66601 291-8832 3005750996 44 M 3005 88 PD
TOZER MD, RICHARD C, 1207 SW 29TH A-10, 66611 4102451363 19 M 4102 53 00	WEBER MD, DARRELL J, 1620 LAKESIDE DR, 66604 1902441570 15 M 1902 44 00
TRAVIS MD, JOHN W, 15 PEPPERTREE LANE, 66611 1606551262 29 M 1606 61 00	WEEKS MD, STACY S, 901 GARFIELD, 66606 354-9591 1902860002 58 F 1902 IM
TREGER MD, NEWMAN V, 1704 W 10TH, 66604 354-8761 1902400547 16 M 1902 40 IM	WELSH MD, NANCY JANE, 1920 PEMBROKE LN, 66604 272-3111 3840631329 39 F 3840 84 IM
TSAI MD, CHIA-HSUN, 823 MULVANE #230, 66606 235-3451 24406730111 47 M 24406 88 AN	WERNER MD, JAMES P, 823 MULVANE, 66606 234-3451 1601841149 58 M 1601 88 DR
TUTUSKA MD, PETER J, 901 GARFIELD, 66606 233-1710 3503821205 56 M 3503 89 CDTs	WILEY MD, THOMAS M, 823 SW MULVANE STE 280, 66606 235-0202 1902861951 59 M 1902 88 08G
UHR MD, NATHANIEL, 3230 SW 18TH, 66604 273-7500 3519210656 00 M 3519 50 IM	WOOD MD, EDWARD R, 901 GARFIELD, 66606 354-9591 1902751404 49 M 1902 IM
VAN SICKLE MD, GREGGORY J, 634 MULVANE STE 410, 66606 235-0335 1606751512 49 M 1606 80 PD	YEH MD, ROBERT M, 823 MULVANE STE 230, 66606 235-3451 24405730061 47 M 24405 82 AN
VANDE GARDE MD, LARRY D, 800 LINCOLN, 66606 233-5101 1803661045 41 M 1803 72 OBG	YORKE JR MD, CRAIG H, 634 SW MULVANE STE 202, 66606 232-3555 2401741367 48 M 2401 80 NS
VOGEL MD, STANLEY J, 823 MULVANE 4TH FL, 66606 354-9591 2802700906 44 M 2802 78 ON	YOUNG MD, PAUL E, 823 MULVANE #240, 66606 233-4927 2407751313 42 M 2407 80 OPH
VOTH MD, ERIC A, 901 GARFIELD, 66606 354-9591 1902810788 55 M 1902 84 IM	YOUNG MD, THEODORE E, 4130 TWILIGHT #123, 66614 2307460745 22 M 2307 51 00
WALIA MD, JAG S, 2200 W TENTH, 66604 234-8601 49529730291 50 M 49515 84 FP	ZACHARIAS MD, DAVID LLOYD, 1500 W TENTH, 66604 354-6031 1902531005 26 M 1902 53 PATH
HALL MD, TERRY J, 1034 MULVANE APT 13, 66604 295-8008 1902821925 54 M 1902 86 RO	ZERBE MD, KATHRYN, BOX 829, 66601 273-7500 4113781772 51 F 4113 79 P
WALLACE MD, BRETT E, 909 MULVANE, 66606 357-0301 4813801251 55 M 4813 ORS	ZIMMERMAN MD, WILLIAM H, 1551 SW WESTOVER RD, 66604 3006520676 20 M 3006 56 00
WALLACE MD, LEO F, 5500 W 24TH, 66614 273-0803 1902410739 17 M 1902 41 EM	
WALLS MD, WILLIAM J, 1 MED PK W BLDG 823 MULVANE, 66606 234-3451 2834661121 39 M 2834 72 OR	
WALZ MD, ROYCE C, 7261 SW FOUNTAINDALE RD, 66614 272-3111 15407600042 27 M 15407 62 P	
WANLESS MD, KIRK M, 823 MULVANE STE 325, 66606 232-8188 2803740898 44 M 2803 81 OT0	
WARD MD, HOWARD N, 823 MULVANE 4TH FL, 66606 354-9591 1606621228 37 M 1606 70 HEM	
WARE MD, LUCILE M, MENNINGER BOX 829, 66601 273-7500 3501531102 29 F 3501 66 P	

TOWANDA — 316
(Sedgwick County Medical Society)

NYBERG MD, FREDRIK F, ROUTE 1, 67144
2101460838
22 M 2101 47 00

TRIBUNE — 316
(Southwest Kansas Medical Society)

MOSER JR MD, ROBERT P, 308 E GREELEY AVE, 67879
376-4251
58 M 1902 90 FP

ULYSSES — 316
(Southwest Kansas Medical Society)

BREWER MD, MARSHALL A, 223 N MAIN, 67880
356-1261 190246DD78
19 M 1902 46 FP

TILLOTSDN MD, DON R, 223 N MAIN, 67880
356-1261 1902650942
32 M 1902 66 FP

VALLEY CENTER — 316
(Sedgwick County Medical Society)

DANIELS MD, ROBERT M, 80X 128, 67147
838-2794 190254D187
24 M 1902 54 FP

WAKEENEY — 913
(Central Kansas Medical Society)

HAMILTON MD, JAMES J, MED CTR 323 RUSSELL, 67672
743-2124 190255D468
30 M 1902 55 FP

LOCKE MD, MARLIN K, 323 RUSSELL, 67672
743-2124 1902831D68
56 M 1902 FP

WAMEGO — 913
(Pottawatomie County Medical Society)

ATWOOD MD, JEFF B, 711 GENN DR, 66547
456-22D7 190287D08D
61 M 1902 FP

BORGENDALE MD, LLEWELLYN V, PD 8DX 7, 66547
456-2291 19026D0082
29 M 1902 61 FP

BRAOEN MD, BILL L, 7D5 COUNTRY CLUB CIR, 66547
456-2291 190260D091
31 M 1902 61 FP

CLARK MD, LAURENCE A, PO BOX 7, 66547
190242D122
12 M 1902 42 00

TACKETT MD, RD8ERT J, 711 GENN DR, 66547
456-2207 1902871728
61 M 1902 FP

WASHINGTON — 913
(Northeast Kansas Medical Society)

HODGSDN MD, DAVID K, 107 E THIRO, 66968
325-2259 1902741581
49 M 1902 80 FP

WATHENA — 913
(Northeast Kansas Medical Society)

PETERSDN JR MD, EVAN A, PD BOX 99, 66090
989-3122 1803550715
24 M 1803 56 FP

WELLINGTON — 316
(Cowley County Medical Society)

ANDERSON MD, LARRY R, 1323 NORTH A, 67152
326-3301 1902730D32
43 M 1902 74 FP

COLE MD, WARO M, 1324 N CHERRY, 67152
190236DD73
08 M 1902 36 00

MCCDRMICK MD, EUGENE CARL, SECURITY STATE BANK BLDG, 67152
326-3914 190256D722
31 M 1902 56 IM

NALDOZA JR MD, FAUSTIND M, 1323 NORTH A STE A, 67152
326-8171 74801653719
38 M 74801 74 GS

PEDRAZA MD, HERNANDD, PO 80X 476, 67152
326-5D26 26404560106
28 M 26404 72 R

WEIGAND MD, JOEL T, 1323 NORTH A, 67152
326-33D1 1902701199
43 M 1902 71 FP

WESTMORELAND — 913
(Pottawatomie County Medical Society)

MINGES MD, TIMOTHY J, 2D8 N 1ST, 66549
457-3311 1902781281
54 M 1902 85 GP

WICHITA — 316
(Sedgwick County Medical Society)

ABAY MD, EUSTAQUIO O, 818 N EMPORIA STE 3D1, 67214
267-5800 74801730578
49 M 74801 NS

AB8AS MD, DILAWER H, 1515 S CLIFTON STE 360, 67218
686-2831 704D27D0091
45 M 70402 77 N

AGUSTIN MD, CONRADO M, 1126 S CLIFTON AVE, 67218
683-3389 7480762DD90
38 M 74807 74 08G

AHLSTRAND MD, RICHARD A, 3243 E MURDOCK STE 1D4, 67208
685-2711 3D05670D20
41 M 3DD5 75 R

AHLSTROM MD, NANCY G, 1035 N EMPORIA STE 1D5, 67214
263-7285 190285D011
59 F 1902 9D IM

ALOOROTY MD, NEIL, 1725 E DOUGLAS, 67211
264-8989 64914753943
46 M 64914 83 P

ALFONSO MD, MANUEL, 3311 E MURDOCK, 67208
689-9445 84710660432
37 M 8471D 72 AN

ALLEN MD, PHILLIP M, WESLEY MED CTR 550 N HILLSIDE, 67214
688-2838 2401540035
27 M 24D1 81 PATH

ALMONT MD, PRISCILLA C, 112D S CLIFTON, 67218
681-2108 74801671954
44 F 74801 78 AN

ALMONTE MD, RODOLFO O, 1515 S CLIFTON STE 48D, 67218
686-3791 74801644353
39 M 74801 78 08G

AMMAR MD, ALEX D, 818 N EMPORIA STE 2D0, 67214
263-0296 51D1760059
51 M 5101 81 GPVS

AMSTUTZ MD, SAMUEL W, 655 N WOODLAWN, 67208
684-5158 1601800027
53 M 1601 0PH

ANDERSON MD, DAVIO J, 3243 E MURDOCK STE 401, 67208
686-7327 1902810893
54 M 1902 84 AN

ANDERSON MD, JAMES D, 3243 E MURDOCK STE 500, 67208
684-0251 1902830045
57 M 1902 84 IM

ARGDSIND MD, RODOLFO, 1148 S HILLSIDE, 67211
683-6506 74801634056
40 M 74801 77 GS

ARTZ MD, TYRONE D, 1507 W 21ST ST N, 67203
267-0362 1803670036
41 M 1803 74 ORS

ASHWORTH MD, ELIZABETH M, 3311 E MURDOCK, 67208
689-9111
57 F 1720 CDS

AUNINS MD, JOHN, 4853 HEMLOCK, 67216
524-6805 4706560110
28 M 4706 58 FP

BACKES MD, DAVIO J, 851 N HILLSIDE, 67214
685-1371 1720770110
48 M 1720 83 U

BAJAJ MD, ASHOK K, 3243 E MURDOCK STE 500, 67208
684-0251 1902820066
58 M 1902 89 CO

BAMMEL MD, BRUCE, 3311 E MURDOCK, 67208
689-9234 2507780116
52 M 2507 82 OBG

BARBA JR MD, ANTONIO P, 1035 N EMPORIA STE 280, 67214
264-2301 74807620341
34 M 74807 76 OBG

BARBA MD, ESTRELLA G, 1035 N EMPORIA STE 280, 67214
264-2301 74802560212
41 F 74802 80 CHP

BARCLAY MD, ANDREW M, 1010 N KANSAS, 67214
261-2622
49 M 80302 88 FP

BARKER MD, BENJAMIN W, 6405 E KELLOGG #23, 67207
1902510041
18 M 1902 51 DO

BARKER MD, PATSY, 818 N EMPORIA STE 303, 67214
265-3774 64914754249
49 F 64914 82 PD

BARON MD, MICHAEL J, 3243 E MURDOCK STE 401, 67208
686-7327 2101860119
59 M 2101 AN

BARTAL MD, ELY, 905 N EMPORIA BOX 3298, 67201
262-7598 39607710019
45 M 39607 81 ORS

BARTH III MD, CHARLES W, 551 N HILLSIDE #41D, 67214
264-8604 2834810061
56 M 401 89 CO

BASS II MD, ORAL E, 851 N HILLSIDE, 67214
685-1371 2803710026
40 M 2803 76 U

BASSELL MD, GERARO M, BOX 782438, 67278
685-4389 14303730037
46 M 14303 82 AN

BASSELL MD, GERARD M, BOX 782438, 67278
685-4389 14303730037
46 M 14303 82 AN

BATES MD, MICHAEL D, 2703 E CENTRAL, 67214
685-6521 3005740109
48 M 3005 75 DBG

BATTISTE MD, CYNTHIA, 1010 N KANSAS, 67214
261-2622 1606730094
00 F PDC

BAUMAN MD, M LEDN, 2828 N GOVERNEOUR, 67226
1902440107
01 M 1902 44 OD

BAUMANN MD, PAUL A, 3333 E CENTRAL STE 214, 67208
688-2920 5605570048
32 M 5605 68 R

BEAMER MD, R LARRY, 818 N EMPORIA STE 200, 67214
263-0296 1902790167
52 M GS

BEATTIE MD, MARY A, 222 S RIDGE RD, 67209
945-5400 1902740658
00 F 1902 PO

BEBAK MD, DONALD M, 3311 E MURDOCK, 67208
689-9445 3515580050
32 M 3515 72 AN

BEBER MD, JORGE H., 1010 N KANSAS, 67214
261-2647 42901780077
54 M 42901 86 P

BECK MD, CHARLES W, 1515 S CLIFTON STE 215, 67218
687-9961 301720360
46 M 301 80 IM

BECKER MD, KARL E, 1650 S GEORGETOWN ST K #200, 67218
686-7327 2307690066
43 M 2307 78 AN

BETHEL MD, CHANOLER S, 6611 E CENTRAL, 67206
682-6559 1902590079
34 M 1902 60 IM

BHARATI MD, RALPH, 8911 E ORME STE A, 67207
686-5151 64933820473
45 M 64933 P

BIERMANN MD, HENRY J, 425 E MURDOCK, 67214
265-6287 3006520072
27 M 3006 52 GS

BIGDNGIARI MD, LAWRENCE R, 929 N ST FRANCIS, 67214
268-5905 1611690211
44 M 1611 R

BINGAMAN MD, ROBERT W, 7111 E 21ST, 67206
684-2851 3901721130
47 M 3901 73 GS

BINYON MD, KERNIE W, BOX 8125, 67208
684-2819 1902560111
24 M 1902 56 FP

BLACK MD, BRYAN L, 1650 S GEORGETOWN ST K #200, 67218
686-7327 1104850096
57 M 1104 88 AN

BLACKMAN MD, JACQUES O, 222 S RIDGE RD, 67209
945-0142 1902760152
51 M 1902 77 FP

BLODM MD, BARRY THEIL, 55D N HILLSIDE, 67214
688-2360 1902810885
56 M 1902 86 PD

BLOOM MD, ROONEY LAMONT, 406 E CENTRAL, 67202
265-0705 1902790248
54 M 1902 80 IM

BLOXHAM MD, THOMAS J, 3311 E MURDOCK, 67208
689-9215 1803750153
50 M 1803 80 PUD

BOLT MD, MICHAEL S, 655 N WOODLAWN, 67208
684-5158 1902832234
55 M 1902 87 OPH

BOND MD, ROGER C, 3243 E MURDOCK STE 500, 67208
684-0251 5606670089
40 M 5606 74 CO

BOUDREAUX MD, VELTIN J, 1325 N COVINGTON CIR, 67212
264-1381 4812640122
37 M 4812 72 R

BOWLES MD, MARK H, 551 N HILLSIDE STE 410 CARDIOL, 67214
684-3838 401750118
48 M 401 87 CD

BOXBERGER MD, GREGORY R, 551 N HILLSIDE #410, 67214
684-3838 1902780242
52 M 1902 CD

BOYO MD, Z REX, 12D S MAIZE RD #12, 67209
3005520052
26 M 3005 56 OO

BRADA MD, DONALD ROBERT, 929 N ST FRANCIS, 67214
268-8680 1902650063
39 M 1902 65 P

BRAOLEY MO,JOHN G, 1131 S CLIFTON, 67218 689-4958 2803770037 51 M 2803 87 FP	BURNEY MO,WILLIAM W, 6608 PEPPERWOOD CT, 67226 4707760066 17 M 1902 52 00
BRAKE MO,DAVIO, 3243 E MURDOCK STE 104, 67208 685-2711 702680051 43 M 702 74 R	BURPEE MO,JAMES F, 851 N HILLSIOE, 67214 685-1371 5605660128 39 M 5605 71 U
BRAUN III MO,WILLIAM T, 3243 E MURDOCK STE 104, 67208 685-2711 2802610087 37 M 2802 67 R	BUTH MO,OENNIS K, 551 N HILLSIOE #410, 67214 684-3838 1902720185 45 M 1902 73 IM
BRAUN MO,KENNETH, 1431 BLUFFVIEW STE 211, 67218 683-4688 3519720158 47 M 3519 78 OPH	BUTIN MO,J WALKER, 38 MISSION RD, 67206 1902470111 23 M 1902 47 00
BRECKBILL MO,DAVIO L, 3333 E CENTRAL #214, 67208 685-1291 1902640050 38 M 1902 65 R	BUTLER MO,ORIS C, 1515 S CLIFTON #150, 67218 684-2329 1902751684 48 F 1902 76 FP
BRINTON MO,E HOLMES, 3311 MURDOCK, 67208 689-9124 2101700154 46 M 2101 77 GS	BYRNE MO,JAMES PERRY, 818 N EMPORIA STE 200, 67214 263-0296 2101680196 42 M 2101 79 TS
BRINTON MO,EDWARD S, 5051 W LINCOLN #8A, 67218 1611410260 15 M 1611 46 00	CALIENOO JR MO,DANIEL J, 550 N HILLSIOE, 67214 688-2222 1902670064 41 M 1902 73 EM
BROOKS MO,LYLE, 2850 S SENECA, 67217 522-5416 3901690099 40 M 3901 FP	CAMPION MO,MARY K, 3311 E MURDOCK, 67208 689-9246 1902800171 51 F 1902 83 IM
BROSIOUS MO,FRANK C, 3243 E MURDOCK STE 500, 67208 684-0251 1902490082 25 M 1902 49 IM	CANNON MO,MICHAEL W, 818 N EMPORIA #403, 67214 262-4467 1902751722 50 M 1902 82 ON
BROWN JR MO,VAL J., 1802 N HYDRAULIC, 67214 265-1461 1902790302 53 M 1902 82 IM	CAPPER MO,STANLEY L, 3311 E MURDOCK, 67208 689-9206 1803670231 37 M 1803 70 D
BROWN MO,DAVIO J, 425 E MURDOCK, 67214 265-6287 1902710139 45 M 1902 72 GS	CARLILE MO,WILLIAM E, 1431 S BLUFFVIEW STE 117, 67218 685-6466 1902830428 53 M 1902 87 AN
BROWN MO,JEFFERY C, 8404 W 13TH STE 180, 67212 722-1982 1902880191 61 M 1902 89 IM	CARLSON MO,TERRY S, 550 N HILLSIOE, 67214 688-2826 3006770117 50 M 3006 79 PATH
BROWN MO,MICHAEL P, 3333 E CENTRAL #504, 67208 683-6766 3005770270 51 M 3007 78 08G	CARR MO,SUSAN L, 1010 N KANSAS, 67214 261-2647 1902860246 59 F 1902 87 P
BROWN MO,ROBERT L, 1515 S CLIFTON #150, 67218 685-6455 1902490091 21 M 1902 49 FP	CARRO MO,ALBERTO F, 1520 S CLIFTON, 67218 689-5775 1902790345 53 M 1902 85 EM
BROWN MO,RONALO C, 818 CARRIAGE PKWY, 67208 685-8231 2803730124 47 M 2803 74 FP	CATE MO,RAIN C, 925 N EMPORIA, 67214 265-2876 4814850264 59 M 4814 86 FP
BROWN MO,RONALO L, 1120 S CLIFTON, 67218 681-2108 3901710111 45 M 3901 72 AN	CAUBLE MO,WILBUR G, 155 S BELMONT, 67218 2834390119 12 M 2834 46 00
BROWN MO,VAL J, 1802 N HYDRAULIC, 67214 265-1461 1003470098 24 M 1003 49 FP	CAUGHLIN MO,GERALD MICHAEL, 818 N EMPORIA STE 101, 67214 263-1574 4812800308 55 M 4812 83 AN
BROWNING MO,WILLIAM H, 7077 E CENTRAL #17, 67206 1902430161 16 M 1902 43 00	CHANEY MO,ERNIE J, 1131 S CLIFTON, 67218 689-5500 1902560200 27 M 1902 56 FP
BRUNER MO,BRAOLEY W, 320 N HILLSIOE, 67214 682-3221 58 M 1902 90 ORS	CHANG MO,FREDERIC C, 818 N EMPORIA STE 200, 67214 263-0296 2401590270 35 M 2401 75 GS
BRUNGAROT MO,GERARD S, 1010 N KANSAS, 67214 261-2650 1902830380 57 M 1902 87 IM	CHAPMAN MO,THOMAS C, 3311 E MURDOCK, 67208 689-9533 58 M 2878 90 IM
BRYANT MO,R KEVIN, 2501 E CENTRAL, 67214 682-6885 512790861 54 M 512 87 FP	CHARO MO,FREDERICK H, 255 S HILLSDALE OR, 67230 5605390082 15 M 5605 48 00
BUBECK MO,RALPH W, 3311 E MURDOCK, 67208 689-9396 1803620187 36 M 1803 68 IM	CHAVEZ MO,STEVE, 3333 E CENTRAL STE 408, 67208 682-0411 1902822051 55 M 1902 85 PO
BUCK JR MO,BEN H, 1208 N CHARLOTTE, 67208 2834430269 17 M 2834 44 00	CHENG MO,MEI Y, 2318 E CENTRAL, 67214 262-2415 1902860271 46 F 1902 87 PO
BURNEY II MO,WILLIAM W, 1755 N MAISON, 67214 264-8311 1902520127 50 M 4707 80 IM	CHERVEN MO,PHILIP L, 3333 E CENTRAL STE 408, 67208 682-0411 2501710311 45 M 2501 77 PO

CHI MD,IL-SUNG, 80X 782438, 67278 685-4389 58302670666 41 M 58302 81 AN	CROW MD,ERNEST W, 402 LONGFORD, 67206 1902440395 20 M 1902 44 00
CHO MD,SECHIN, 1010 N KANSAS, 67214 261-2622 58302710048 47 M 58302 77 PO	CROWLEY MD,EOWARD X, 5 PARK AVE, 67206 1643400258 14 M 1643 45 00
CHOPRA MD,RAMAN, 3333 E CENTRAL #201, 67208 685-5271 49514740037 52 M 49536 78 PD	CUMMINGS MD,RICHARD J, 427 N HILLSIDE, 67214 686-6608 1902570159 32 M 1902 57 0TO
CHRISTMAN JR MD,CARL, 550 N LORRAINE, 67214 685-0559 4802740404 48 M 4802 75 OBG	CZAPANSKY-BEILMAN MD,OESIREE, 550 N HILLSIOE, 67214 688-3110 1902860386 59 F 1902 89 PO
CLAIBORNE MD,RICHARD A, 3243 MURDOCK STE 500, 67208 684-0251 1902800227 55 M 1902 80 IM	DAKHIL MD,SHAKER R, 818 N EMPORIA STE 403, 67214 262-4467 60501750088 50 M 60501 80 IM
CLARK MD,COURTNEY, 1120 S CLIFTON, 67218 681-2108 1902560242 30 M 1902 56 AN	DAMIANI DO,STEPHEN M, 3311 E MURDOCK, 67208 689-9367 57 M 2879 90 END
CLARK MD,FRANCIE H, 3243 E MURDOCK STE 303, 67208 688-3070 1902870381 57 F 1902 89 FP	DANBY MD,JOHN H, 2535 E LINCOLN, 67211 265-2876 91705560019 29 M 35205 83 FP
CLARK MD,ROBERT G, 7015 E CENTRAL, 67208 652-9221 1902780340 53 M 1902 79 PS	DARGER MD,KATHERINE, 3243 E MURDOCK STE 401, 67208 686-7327 1902860416 57 F 1902 90 AN
CLIFTON MD,H DAVID, 3600 E HARRY, 67218 689-5050 401650199 41 M 401 70 R	DARRAH MD,JOY N, 8100 E 22NO ST N 8LDG 1600, 67226 681-1827 1902741930 49 F 1902 77 R
CLINE MD,RYRON W, 551 N HILLSIOE STE 510, 67214 685-0559 4802770354 51 M 4802 78 O8G	DAVISON MD,RANoy G, 550 N HILLSIDE, 67208 688-2239 2846800096 55 M 2846 81 EM
COATS MD,BARBARA S, 222 S RIDGE RD, 67209 945-0142 1902830444 57 F 1902 84 FP	DAVIS MD,PAUL H, 7111 E 21ST, 67206 684-2851 3901720168 47 M 3901 73 FP
COFFEY MD,CHARLES R, 3243 E MURDOCK STE 401, 67207 686-7327 1902820350 55 M 1902 AN	DAVIS MD,RONALO B, 7322 CEDARIOGE CIR, 67226 685-2153 1902720291 46 M 1902 73 FP
COHEN MD,JUSTIN THOMAS, 655 N WOODLAWN, 67208 684-5158 2803740138 47 M 2803 78 OPH	DAVISON MD,JOE O, 8200 W CENTRAL #1, 67212 721-4544 3901810370 54 M 3901 84 FP
COHLMIA MD,JERRY B, 818 N EMPORIA STE 310, 67214 263-5891 1902700133 43 M 1902 71 IM	OAY MD,HOWARD, 818 N EMPORIA STE 310, 67214 263-5891 1902740194 48 M 1902 76 NEP
COLEMAN MD,THOMAS J, 155 N CRESTWAY, 67208 3545510153 18 M 3545 54 00	OE 8AKKER MD,JAN 8, 633 N 8ROADMOOR AVE, 67206 5104590201 25 M 5104 66 00
COLLIER MD,HAROLD W, 1650 S GEORGETOWN ST K #200, 67218 686-7327 1902710236 45 M 1902 72 AN	DE BOISE MD,DOUGLAS, 2020 N WOODLAWN STE 550, 67208 269-4355 3006770192 52 M 3006 89 O8G
CONCEPCION JR MD,EUGENIO S, 1515 S CLIFTON STE 480, 67218 684-1048 74802640785 39 M 74802 74 CD	DE HART MD,ARTHUR OONIVA, 2703 E CENTRAL, 67214 685-1277 4804771951 50 M 4804 78 OBG
CONRRARDY MD,PETER A, 818 N EMPORIA #101, 67214 263-1574 515690191 42 M 515 76 AN	OEGNER MD,JAMES C, 3600 E HARRY, 67208 689-5050 1902840482 57 M 1902 DR
COOK MD,DONALD RAY, 315 N HILLSIDE STE A, 67214 686-3392 2012710138 42 M 2012 72 FP	DEJONG MD,OAVIO C, PO 80X 12667, 67279 722-6366 2501590331 33 M 2501 71 PATH
COOK MD,G EDWARD, 144 S HILLSIDE, 67211 685-9289 401670181 42 M 401 69 R	DELMORE MD,JAMES E, 3243 E MURDOCK LEVEL 8, 67208 681-0251 4804782431 50 M 4804 80 GYN
COOPER MD,M KENT, 1650 S GEORGETOWN ST K #200, 67218 686-7327 1902790426 54 M 1902 80 AN	DEMOSS MD,ELEANOR P, 3333 E CENTRAL STE 407, 67208 682-5591 74802660361 42 F 74802 77 PD
COSSMAN MD,F PRICE, 851 N HILLSIDE, 67214 685-1371 1902570124 28 M 1902 57 U	DEPEW MD,CLIFFORD S, 345 N HILLSIDE, 67214 682-4572 1902860475 60 M 1902 90 OBG
CRANE MD,DAVID D, 929 N ST FRANCIS, 67214 268-5414 2501600230 34 M 2501 73 PATH	DOAN MD,TRINAH, 959 N EMPORIA STE 2 B, 67214 267-5580 94101620195 32 M 94101 82 GP
CRONIN MD,DONALD J, 618 RUTLAND, 67206 26044400247 16 M 2604 48 00	DOEBLIN MD,P LAURENCE, 3333 E CENTRAL STE 214, 67208 685-1291 1002730312 40 M 1002 82 R

<p>OOLAN JR MO, PHILIP JARVIS, 3311 E MURDOCK, 67208 689-9241 2105730317 47 M 2105 79 GE</p> <p>OONATLE MO, EDWARD P, UKSM - WICHITA 1010 N KANSAS, 67214 261-2607 2604510204 22 M 2604 79 FP</p> <p>OONNELL MO, JAMES M, 758 S HILLSIDE, 67277 687-4421 1902550298 28 M 1902 55 FP</p> <p>OORNBOS MO, DANIEL C, 3311 E MURDOCK, 67208 689-9355 1902840512 58 M 1902 IM</p> <p>OORN MO, CURTIS C, 550 N HILLSIDE, 67214 688-2360 1902830576 57 M 1902 83 PO</p> <p>OORSCH MO, JOHN N, 1131 S CLIFTON, 67218 689-4958 1902790515 54 M 1902 FP</p> <p>OOUTHIT MO, DOUGLAS OAVIO, 551 N HILLSIDE STE 510, 67214 685-0559 4802790487 53 M 4802 80 08G</p> <p>OWNING MO, GREGORY C, 551 N HILLSIDE #410, 67214 684-3838 1902790531 52 M 1902 R</p> <p>ORAKE MO, RALPH L, 4422 E 3RD, 67208 4102260177 99 M 4102 37 00</p> <p>ORAZEK MO, GEORGE, 3311 E MURDOCK, 67208 689-9316 3506760339 50 M 3506 81 OPH</p> <p>ORAZEK MO, JANE K, 3600 E HARRY, 67218 689-4774 3506760673 49 F 3506 81 P</p> <p>OREVETS MO, CURTIS C, 3311 E MURDOCK, 67208 689-9178 1902560331 30 M 1902 56 IM</p> <p>DUGAN MO, OAVIO L, 1431 S BLUFFVIEW STE 117, 67218 685-6466 1902870501 56 M 1902 88 AN</p> <p>DUICK MO, GREGORY, PO BOX 47669, 67201 265-1308 1643720325 46 M 1643 77 CO</p> <p>OURANO MO, ANTONIO C, 959 N EMPORIA STE 401, 67214 263-7893 74807560160 29 M 74807 65 U</p> <p>OUTTA MO, SAKUNTALA S, 8118 WINOWOOD CIR, 67226 687-9177 49550650249 42 F 49550 87 R</p> <p>ECKERT MO, WILLIAM G, 7006 E TENTH, 67206 685-7612 3519520248 26 M 3519 67 PATH</p> <p>EDWARDS MO, MANIS C, 1102 N ARMOUR, 67206 3005580179 33 M 3005 65 00</p> <p>EGBERT MO, ANNE MARSH, UKSM WICHITA 1010 N KANSAS, 67214 261-2622 3840791229 54 F 3840 80 IM</p> <p>EGELHOF MO, RICHARD H, 222 S RIOGE RD, 67209 945-0142 1902730334 45 M 1902 75 FP</p> <p>EINSPAHR MO, OAVIO E, 3243 E MURDOCK STE 300, 67208 681-0736 3005801990 54 M 3007 87 ON</p> <p>ELANGOVAN MO, SUOHA, 1010 N KANSAS, 67214 261-2607 1902870527 45 F 1902 89 FP</p> <p>ENOCH MO, ROLLANO, 3236 N ROCK RD #190, 67226 681-0423 64914762101 49 M 64914 78 FP</p> <p>ERNST MO, TARI MAE, 818 CARRIAGE PKWY, 67208 651-2202 3005810115 56 F 3005 FP</p>	<p>ESTEP MO, THOMAS H, 818 N EMPORIA STE 200, 67214 263-0296 6002750161 51 M 6002 82 CO</p> <p>ESTIVO O O, MICHAEL P, 501 N MAIZE RD, 67212 721-8800 2879850765 57 M 2879 90 ORS</p> <p>EVANS MO, FARRIS O, 521 RUTLAND RD, 67206 1902320161 05 M 1902 32 00</p> <p>EVANS MO, JOHN F, 550 N HILLSIDE, 67214 688-2360 2803700225 42 M 2803 71 MFM</p> <p>EVANS MO, ROGER WILLIAMS, 933 N TOPEKA, 67214 263-5889 1902640238 39 M 1902 65 CO</p> <p>EYSTER MO, ROBERT L, 3243 E MURDOCK STE 200, 67208 685-1491 3901730414 47 M 3901 74 ORS</p> <p>FARHA MO, AYHAM J, 851 N HILLSIDE, 67214 685-1371 59 M 60501 U</p> <p>FARHA MO, GEORGE J, 818 N EMPORIA STE 200, 67214 263-0296 2101570358 27 M 2101 64 GS</p> <p>FARHA MO, S JIM, 818 N EMPORIA SUITE 200, 67214 263-0296 1001570419 31 M 1001 65 TS</p> <p>FARHAT MO, ASSEM Z, 3243 E MURDOCK STE 500, 67208 684-0251 87501830061 60 M 87501 90 CO</p> <p>FARLEY MO, JAMES A, ST JOSEPH MED CTR 3600 E HARRY, 67218 689-5671 1902782229 50 M 1902 82 PATH</p> <p>FEAREY MO, ALAN J, 3311 E MURDOCK, 67208 689-9410 1902780609 53 M 1902 80 IM</p> <p>FELT MO, SAMUEL E, 550 N HILLSIDE, 67214 688-2825 46 M 1902 75 PATH</p> <p>FERNANDEZ MO, HECTOR O, 1515 S CLIFTON STE 460, 67218 683-2299 74809660129 41 M 74809 76 GS</p> <p>FERRIS MO, BRUCE G, 825 N HILLSIDE, 67214 688-7500 1902690324 43 M 1902 70 PS</p> <p>FEUILLE JR MO, EOMONO G, 551 N HILLSIDE #510, 67214 685-0559 4802750531 50 M 4802 76 08G</p> <p>FIELOS O O, STEPHEN, 7200 W 13TH, 67212 721-1200 2878720086 42 M 2878 73 FP</p> <p>FISHER MO, RAY F, 3243 E MURDOCK STE 500, 67208 684-0251 1902742227 49 M 1902 77 IM</p> <p>FITZGERALD MO, EDWARD J, 3600 E HARRY, 67218 689-5050 3006500152 22 M 3006 50 R</p> <p>FITZIG MO, SANFORD, 3311 E MURDOCK, 67208 689-9185 4102720640 46 M 4102 79 U</p> <p>FLATT MO, OAVIO, 551 N HILLSIDE #410, 67214 684-3838 1803750374 45 M 1803 CD</p> <p>FLEMING MO, FORNEY W, 551 N HILLSIDE #210, 67214 686-1010 4802690431 43 M 4802 75 ORS</p> <p>FLOWERS JR MO, CLELL B, 855 N HILLSIDE, 67214 685-1381 1902550395 22 M 1902 55 FP</p> <p>FORO MO, CHARLES R, 232 S MAIZE RD, 67209 722-0568 1902630241 38 M 1902 64 OPH</p>
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FORREO MD,WALTER, 551 N HILLSIDE STE 410, 67214

684-3838
43 M 1902 70 GER

FOWLER MO,ROBERT J, 3311 E MURDOCK, 67208

689-9236 2802630169
37 M 2802 70 IM

FRANCIS MO,NORTON L, 55 VIA ROMA, 67230

3005350254
10 M 3005 46 00

FRANCISCO MO,DAN A, 551 N HILLSIDE #410, 67214

264-8604 1803751508
40 M 1803 81 CD

FRANCISCO MO,LINO A L, 818 N EMPORIA STE 310, 67214

263-5891 1803741448
47 F 1803 82 NEP

FRENCH MD,JAMES E, 1515 S CLIFTON #420, 67218

684-5237 3005780437
53 M 3005 80 GS

FRENCH MD,JEROME E, 310 S HILLSIDE, 67211

684-2838 1103710223
44 M 1103 82 OTO

FRITZE MD,MARK H, 3600 E HARRY, 67218

689-5050
58 M 3901 90 DR

FRITZEMEIER MD,WILLIAM H, 7373 E 29TH N II E311, 67226

1902410178
14 M 1902 41 00

FROMER MD,JOEL, 2627 E CENTRAL, 67214

684-0501 16506750095
46 M 16501 81 A

FROMM MD,ARTHUR H, 315 N HILLSIDE STE C, 67214

685-2281 1902630267
37 M 1902 64 FP

FULTON MD,JOHN K, 236 S TERRACE DR, 67218

5605430360
18 M 5605 50 00

GAGNON MD,SUZANNE, 1010 N KANSAS, 67214

261-2650
56 F 2405 IM

GALICHIA MD,JOSEPH P, 551 N HILLSIDE #410, 67214

684-3838 1902690413
42 M 1902 70 CD

GALVAN MD,ALONSO, 3243 E MURDOCK STE 500, 67208

684-0251 64906640013
38 M 64906 72 IM

GARONER MD,JARED J, 550 N HILLSIDE, 67214

688-7700 801710964
44 M 801 89 PATH

GAUGHAN EXEC DIR,CAROLYN N, KANSAS ACAAEMY OF FMLY PHYS,

67203
652-7244
00 F

GENILO MD,CELESTE A, 3311 E MURDOCK, 67208

689-9445 74801623470
39 F 74801 62 AN

GEORGE MO,EARL F, 2146 N OLO MANOR, 67208

681-3320 1902650268
35 M 1902 66 FP

GILLENWATER MD,DAVID T, 818 N EMPORIA STE 101, 67214

263-1574 1902860611
60 M 1902 AN

GILMARTIN MD,RICHARD C, 2620 E CENTRAL, 67214

686-6866 4112580269
32 M 4112 77 PON

GOERING MO,RANOALL V, 1969 W 21ST, 67203

832-9024 1902840644
58 M 1902 85 FP

GOLD8ERG MD,HERBERT R, 1515 S CLIFTON AVE #440, 67218

682-9130 3508590309
33 M 3508 64 PD

GOLDSTEIN MO,ESTELLE T, 1010 N KANSAS, 67214

261-2647 39620800019
53 F 39620 89 P

GONZALEZ MD,HIRAM, 1431 S 8LUFFVIEW DR #203, 67218

681-1384 64901520575
20 M 64901 71 P

G000 O O,FREDERICK C, 550 N HILLSIDE, 67214

688-2222
51 M 2878 79 EM

G000PASTURE MD,HEWITT C, 818 N EMPORIA STE 305, 67214

264-3505 1902690448
43 M 1902 70 IM

G0ROON MO,JAMES R, 3311 E MURDOCK, 67208

689-9260 1611781071
53 M 1611 83 IM

GOYLE MD,KRISHAN K, 1150 N ST FRANCIS, 67214

267-9906 49529640055
34 M 49529 76 CD

GOYLE MD,VIMAL, 1150 N ST FRANCIS, 67214

267-9906 49529670108
41 F 49529 76 08G

GRAINGER MD,DAVIO A, 2903 E CENTRAL, 67214

687-2112
55 M 1902 ENO

GRANT MD,MICHAEL E, 818 N EMPORIA STE 310, 67214

263-5891 1902850658
59 M 1902 86 N

GRAUEL MO,CHARLES W, 14821 SHARON LN, 67230

733-0667 1902700451
44 M 1902 71 AN

GRAVES MD,JACK W, 610 RUTLAND, 67206

1902420246
17 M 1902 42 00

GRAY MD,C LUCIEN, 3311 E MURDOCK, 67208

689-9227 1902450293
21 M 1902 45 ENT

GRAY MD,H TOM, 9 VIA ROMA, 67230

401440313
19 M 401 55 00

GREER MD,JAMES A, 3311 E MURDOCK, 67208

689-9227 1611690688
43 M 1611 78 OTO

GRENE MD,ROBERT BRUCE, 550 N LORRAINE, 67214

682-2020 1902780706
53 M 1902 OPH

GRI8EL MD,DONNA J, 3243 E MURDOCK #300, 67208

681-0736 1902850674
58 F 1902 89 ON

GRINDEL 00,STEPHEN J, 7150 E HARRY, 67207

687-2651 2878860406
56 M 2878 87 FP

GROSS MO,BRIAN M, 1035 N EMPORIA #265, 67214

269-4026 2803820336
56 M 2803 PM

GRUSHNYS MD,ARNOLD, 14419 TIPPERARY CIR, 67230

40721590111
19 M 40721 70 00

GSELL MD,GEORGE F, 7373 E 29TH ST N #W104, 67226

1601340492
07 M 1601 34 00

GUTHRIE MD,RICHARD A, 1515 S CLIFTON STE 250, 67218

687-3100 2803600204
35 M 2803 73 PO

HABASHY MD,SHAWKY N F, 8404 W 13TH STE 230, 67212

722-6109 33004650056
43 M 33004 80 08G

HAGAN MD,C THOMAS, UKSM WICHITA 1010 N KANSAS, 67214

261-2622 3006420205
16 M 3006 42 IM

HAGAN MO,FRANCIS J, 14817 E 29TH NORTH, 67228

3006390314
13 M 3006 39 00

HAGAN MD,ROBERT C, 3311 E MURDOCK, 67208

689-9306 1902770573
52 M 1902 82 GE

HAGAN MD,STEPHEN F, 1250 W MAPLE, 67213 262-1057 2834800503 53 M 2802 81 PUD	HEREO MO,JOHN, 1515 S CLIFTON #370, 67218 686-7222 2802670292 41 M 2802 73 N
HALL MD,J ROGER, 1148 S HILLSIDE #107, 67211 685-5227 4802680517 42 M 4802 76 OPH	HERSHBERGER DD. ,GROVER, 1245 N WEST ST, 67203 945-6910 2878790424 47 M 2878 80 GP
HARRIS MD,FRANK H, 2026 N OLD MANOR, 67208 1001390208 09 M 1001 39 00	HERSHORN MO,SIMON E, 9117 LAKEPOINT, 67226 1902460205 22 M 1902 46 00
HARRISON MO,PAUL BARRY, 3243 E MURDOCK STE 404, 67208 685-6222 1902742154 49 M 1902 78 GS	HESSE MD,JAMES F, 818 CARRIAGE PKWY, 67208 685-8231 1902820775 54 M 1902 FP
HART MD,DILLIS L, 1515 S CLIFTON STE 300, 67218 688-0135 3901640369 36 M 3901 67 GS	HETT MD,EDWARD J, 1969 W 21ST, 67203 832-9024 1902810401 55 M 1902 82 FP
HART MD,JOHN J, 3243 E MURDOCK STE 303, 67208 688-3070 2803800424 53 M 74808 78 GP	HIGHTOWER MD,CURTIS E, 1650 S GEORGETOWN ST K #200, 67218 686-7327 55 M 3806 AN
HARTLEY MD,FOUNT K, 3007 E CENTRAL, 67214 686-7369 1902530343 25 M 1902 53 GS	HILL MD,LARY M, 1131 S CLIFTON, 67218 689-6410 1902770646 51 M 1902 78 FP
HARTLEY MD,JAMES M, 818 CARRIAGE PKWY, 67208 685-8231 2604710581 45 M 2604 79 FP	HINSHAW JR MD,CHARLES T, 1133 E SECOND, 67214 262-0951 1902580413 32 M 1902 59 PATH
HARTMAN MD,KECK R, 818 N EMPORIA STE 305, 67214 264-3505 1902820708 55 M 1902 ID	HINSHAW MD,ALFRED H, 1655 GEORGETOWN #307, 67218 1902330221 D7 M 1902 33 00
HARTWELL MD,KIMBERLY, 855 N HILLSIDE, 67214 685-1381 1902821828 56 F 1902 83 FP	HIZON MD,RAMON R, 929 N ST FRANCIS, 67214 268-5906 74801622503 38 M 74801 62 DR
HARTWELL MD,RICK L, 855 N HILLSIDE, 67214 688-2222 1902820716 83 M 1902 83 FP	HODSON MD,HERVEY R, 8809 E HARRY APT 909, 67207 160631D516 03 M 1606 31 00
HARVEY MD,ROSEMARY 8, 2230 CAROINAL DR, 67204 1902490287 24 F 1902 49 00	HOLDEN JR MD,RAYMOND F, 262 S BROOKSIDE, 67218 2802330394 10 M 2802 56 00
HASKINS MD,ROBERT J, 1010 N KANSAS, 67214 689-5500 1902740445 46 M 1902 75 FP	HOLLIS MD,KENNETH W, 7015 E CENTRAL, 67208 652-9221 1902790922 54 M 1902 GS
HASSAN MD,RIZWAN U, 1515 S CLIFTON STE 36D, 67218 686-2831 70404710131 47 M 70404 70 N	HOLLOWAY MD,KEVIN B, 1035 N EMPORIA #130, 67214 264-3222 1902840831 57 M 1902 85 P
HASTINGS MD,GLEN E, 1010 N KANSAS (S H BULLER), 67214 261-2650 1902620342 32 M 1902 67 IM	HOLMES MD,JED, 7111 E 21ST, 67206 684-2851 300578D593 53 M 30D5 79 FP
HAVEY MO,DAVID, 3243 E MURDOCK STE 401, 67208 686-7327 50 M 1645 AN	HOLT MD,JOHN M, UKSM WICHITA 1010 N KANSAS, 67214 684-2169 1902610380 35 M 1902 62 IM
HAWLEY MO,RAYMOND G, 929 N ST FRANCIS, 67214 268-5559 1902650357 39 M 1902 66 PATH	HDR8ELT MD,DOUGLAS V, 3243 E MURDOCK L-G, 67208 681-0251 4802721744 47 M 4802 73 08G
HAYES MD,WILLIAM L, 3243 E MURDOCK STE 500, 67208 684-0251 1902530351 28 M 1902 53 CD	HORSLEY MD,JAMES I, 25D1 E CENTRAL, 67214 683-6613 64933800081 46 M 64933 PM
HAYNES MO,OE80RAH G, 8100 E 22ND ST N #2200, 67226 683-4334 1902790833 54 F 1902 80 FP	HOUSHOELER MD,DANIEL FAIR, 929 N ST FRANCIS, 67214 268-5915 19027DD559 43 M 1902 71 NM
HAYS MD,THOMAS H, 7111 E 21ST, 67206 684-2851 1902750505 49 M 1902 76 FP	HOUSHOLDER MD,MARTHA S, 835 N HILLSIDE, 67214 685-4395 1902720991 46 F 1902 73 D
HEALY MD,PATRICK M, 818 N EMPORIA STE 101, 67214 263-1574 3006820408 56 M 3006 86 AN	HOWARD MO,DOONALO O, 82 VIA VERDE, 67230 1902380236 11 M 1902 38 00
HELLMAN MO,DAVID W, 1520 S CLIFTON, 67218 689-5775 1902870721 59 M 1902 88 EM	HUGHES D O,STEVEN R, 1520 S CLIFTON, 67218 689-5775 2878820048 49 M 2878 83 FP
HENWOOD MO,JOHN R, 76D2 E HARRY, 67207 682-7411 3901820707 52 M 3901 85 FP	HUGHES MD,JOHN D, 818 N EMPORIA STE 200, 67214 263-0296 19028D0529 51 M 1902 81 GS
HER8OLO MO,DAVID R., 550 N HILLSIDE, 67214 688-770D 2802761433 42 M 2802 88 PATH	HULTGREN MO,MYRON K, 2456 N WOODLAWN, 67220 685-1382 1902681163 41 M 1902 69 FP

HUMMER MO, LLOYD M, 3311 E MURDOCK, 67208 689-9323 3901570298 32 M 3901 66 IM	JOHNSON MO, GEORGE K, UKSM WICHITA 1010 N KANSAS, 67214 261-2622 1205670277 40 M 1205 79 IM
HUNO MD, LARRY R, 3333 E CENTRAL STE 408, 67208 682-0411 1902780838 52 M 1902 81 PO	JOHNSON MO, MATTHEW S, 7150 E HARRY, 67207 687-2561 1902850887 59 M 1902 87 FP
HUNNINGHAKE MO, RONALD, 3100 N HILLSIDE, 67219 682-3100 1902760616 51 M 1902 82 FP	JOHNSON MO, TERESA K, 818 CARRIAGE PARKWAY, 67208 651-2210 1902850895 58 F 1902 86 FP
HUSTEAO MD, ROBERT F, 2401 N PERSHING, 67220 681-0451 801540309 28 M 801 63 AN	JOHNSON MO, THOMAS E, 3333 E CENTRAL STE 214, 67208 685-1291 1643670387 41 M 1643 75 R
HUTCHINSON MO, STEVEN A, 551 N HILLSIDE #550, 67214 682-2911 1902840920 59 M 1902 GS	JOHNSTON MO, SARAH C, 5500 E KELLOGG, 67218 685-2221 1902760314 51 F 1902 IM
HUYCKE MO, EDWARD J, 5500 E KELLOGG, 67218 651-3603 1902530424 28 M 1902 53 IM	JONES MD, JAY S, 1507 W 21ST, 67203 838-2020 64914770864 50 M 64914 ORS
HYOER MO, JACE W, 1431 S BLUFFVIEW STE 210, 67218 687-1090 1902790990 52 M 1902 CRS	JONES MO, JON K, 550 N HILLSIDE, 67214 688-2222 1902830983 55 M 1902 88 IM
HYNES MO, HENRY E, 818 N EMPORIA STE 403, 67214 262-4467 53902580120 35 M 53902 65 HEM	JONES MO, ROONEY, 1040 RUTLAND, 67206 652-9221 1803820798 56 M 1803 84 AN
IBARRA MO, J LUIS, 961 PARKLANE, 67218 685-0201 64901460084 20 M 64901 59 P	JOSEPH JR MO, JAMES, 3243 E MURDOCK STE 200, 67208 685-1491 702840571 56 M 702 ORS
ICHTERTZ MO, GREG L, 551 N HILLSIDE STE 410, 67214 684-3838 53 M 74801 PUO	JUST MO, GARY O, 1035 N EMPORIA ST #270, 67214 685-5211 1902770778 51 M 1902 78 GS
IOBEIS MO, BAOR, 818 N EMPORIA #200, 67214 263-1177 87501720591 47 M 87501 80 TS	JUOILLA JR MO, FRANCISCO, 818 N EMPORIA STE 101, 67214 263-1574 74811710451 44 M 74801 76 AN
ISAACS MO, JUANITA J, 2939 N ROCK RD, 67226 684-0201 2101720538 43 F 2101 84 P	KADER MO, GIHAN S, 3311 E MURDOCK, 67208 689-9137 49 F 60501 N
JACKSON MO, CHARLES R, 1035 N EMPORIA STE 135, 67214 263-0812 1606530486 27 M 1606 60 GS	KAISON MO, HERBERT I, 929 N ST FRANCIS, 67214 268-5916 1611690921 44 M 1611 75 R
JACOB MO, KANNAMPALLY L, 1515 S CLIFTON STE 320, 67218 689-8899 49537590075 31 M 49537 76 U	KAHN MD, OAVIO M, 3311 E MURDOCK, 67208 689-9316 3843790517 54 M 3843 85 OPH
JADHAV MO, KISHOR B, 818 N EMPORIA STE 101, 67214 263-1574 49517710040 48 M 49517 76 AN	KAROATZKE MO, E STANLEY, 151 N MAIN STE 300, 67202 1720640721 39 M 1720 65 OO
JAMES MD, DONALD L, 1301 N WEST, 67203 945-5245 3901710553 42 M 3901 81 OTO	KAROATZKE MD, JON K, 8200 W CENTRAL STE 1, 67212 721-4544 1720620673 36 M 1720 65 FP
JAMES MO, PHILIP C, 3311 E MURDOCK, 67208 689-9442 1902840954 51 M 1902 86 PO	KASHA MD, ROBERT L, 8454 E MT VERNON, 67207 2834380504 11 M 2834 46 OO
JANSSON MO, KENNETH A, 905 N EMPORIA, 67214 262-7598 58 M 3201 91 ORS	KASSEBAUM MD, KENNETH G, 8911 E ORME, 67207 686-5108 1606600557 34 M 1606 75 CHP
JEHAN MO, SAYEO S, 635 N MAIN, 67202 268-8036 70403590141 33 M 70403 75 P	KATER MO, ERIC O, 3600 E HARRY, 67218 689-5050 1902820899 56 M 1902 87 OR
JENNEY MO, CHARLES B, 818 N EMPORIA SUITE 200, 67214 263-0296 2834610364 34 M 2834 68 GS	KAUFMAN MD, EUGENE E, 3243 E MURDOCK STE 200, 67208 685-1491 1902560617 30 M 1902 56 ORS
JENSEN MO, OARAN L, 551 N HILLSIDE STE 540, 67214 685-7234 3005790645 52 M 3005 80 OBG	KEITH MD, REX B., 925 N. EMPORIA, 67214 263-2207 1902850909 59 M 1902 FP
JOHNSON MO, CAROL ANN, 3243 E MURDOCK SUITE 303, 67208 688-3070 1902770727 49 F 1902 78 FP	KELLER MO, JAMES P, 1431 S BLUFFVIEW STE 112, 67218 685-1284 1902740631 48 M 1902 75 IM
JOHNSON MO, CAROLYN K, WESLEY MED CTR 550 N HILLSIDE, 67214 688-2360 1902800570 48 F 1902 81 NPM	KENAGY MO, ROBERT S, 7717 E 29TH N, 67226 636-5585 1902870900 57 M 1902 FP
JOHNSON MD, OAVIO B, 818 N EMPORIA STE 403, 67214 262-4467 702800561 54 M 702 HEM	KENOALL MO, TOM E, 825 N HILLSIDE, 67214 688-7500 3901620422 37 M 3901 70 PS

KENORICK MD,J GILLERAN, 550 N HILLSIDE, 67214 688-2088 1902460311 20 M 1902 47 ADM	KNIGHT MO,PHILIP J, 818 N EMPORIA STE 200, 67214 263-0296 502680650 42 M 502 82 POS
KENNEOY MD,GERALO T, 551 N HILLSIDE STE 410, 67214 684-3838 1902610444 35 M 1902 62 GE	KOEHN MD,NORMAN S, 3311 E MURDOCK, 67208 687-5859 3901851815 49 M 3901 IM
KETTERMAN MD,DIANA K, 2757 S SENECA, 67217 264-5182 1902852111 58 F 1902 87 FP	KOURI MD,SAMMY H, 551 N HILLSIDE STE 550, 67214 682-2911 3901570387 33 M 3901 62 GS
KEYES MD,MICHAEL J, 2939 N ROCK RD, 67226 684-0201 2101700669 44 M 2101 84 P	KRAUSE MD,ROLANO L, 230 S RUTAN, 67218 1902530505 25 M 1902 53 OO
KHICHA MD,GYANCHANO J, 818 N EMPORIA STE 200, 67214 263-0296 49530610071 37 M 49530 73 TS	KREADY MD,JOHN L, 818 CARRIAGE PKWY, 67208 685-8231 1902791091 48 M 1902 80 FP
KHOURY MD,GEORGE H, 3333 E CENTRAL STE 416, 67208 681-2021 33002550101 32 M 33002 75 PD	KUBINA MO,GLENN RICHARD, MID-KS ENT ASSN 310 S HILLSIDE, 67211 684-2838 3840730831 47 M 3840 79 OT0
KILGORE III MD,WILLIAM R, 3311 E MURDOCK, 67208 689-9111 58 M 3901 90 GE	KUMAR MD,ARUN, 3333 E CENTRAL #816, 67208 685-5326 49529740106 50 M 49529 85 PO
KIM MD,PAIK N, 3243 E MURDOCK SUITE 300, 67208 681-0736 58302580403 33 M 58302 75 HEM	KURTH MD,C JOSEPH, 200 S ROCK RD STE H, 67207 3006350312 10 M 3006 37 OO
KINDEL MD,VICTORIA W, 551 N HILLSIDE #540, 67203 685-7234 59 F 1902 87 08G	LAI MO,CHUEN-HUEY, 929 N ST FRANCIS, 67214 268-5428 24405780051 53 F 24405 88 PATH
KIPPERMAN MD,ROBERT M, 551 N HILLSIDE STE 410, 67214 684-3838 53 M 30501 CO	LAI MO,JENG Y, 8501 KILLARNEY PL, 67206 265-4701 38502670201 41 M 38502 77 TS
KIRK JR MD,E DAVID, 1431 S BLUFFVIEW DR STE 209, 67218 685-1351 1902620440 34 M 1902 63 IM	LANCE JR MD,JOHN F, PO BOX 8206, 67208 1902450382 20 M 1902 45 OO
KIRSCH MD,MARK A, 1650 S GEORGETOWN ST K #200, 67218 686-7327 1902820953 53 M 1902 85 AN	LATIMER MO,KATHERINE, 1650 S GEORGETOWN ST K #200, 67218 686-7327 401750576 49 F 1205 78 AN
KISER MO,JOHN L, 3243 E MURDOCK STE 404, 67208 685-6222 2802620465 37 M 2802 65 GS	LAWN MO,CLAUDIO A, 144 S HILLSIDE, 67211 685-3411 1902751536 50 F 1902 77 R
KISER MD,WILLARD J, 1446 WILLOW RD, 67208 4705300211 05 M 4705 34 OO	LAWN MD,RAYMOND A, 715 N MISSION RD, 67206 683-8991 2604360431 09 M 2604 49 AM
KITCHEN MD,ROBERT R, 3420 E DOUGLAS, 67208 685-2355 1902520399 26 M 1902 52 CHP	LEAR MO,REX V, 8911 E ORME STE D, 67207 686-5195 1902861048 60 M 1902 87 P
KLAFTA MD,LEONARD A, 3311 MURDOCK, 67208 689-9423 1611620817 37 M 1611 87 NS	LEE JR MD,EDWARD S, 2002 E 17TH, 67214 4707370195 09 M 4707 52 OO
KLEIN MO,TERRY D, 7602 E HARRY, 67207 682-7411 1902850941 55 M 1902 FP	LEE MD,MARTIN W, 3243 E MURDOCK STE 300, 67208 681-0736 4814820870 56 M 4814 86 ON
KLINGMAN MO,DIANE D, 8100 E 22ND ST N #2200, 67226 683-4334 1902790493 53 F 1902 80 FP	LEE MD,R REX, 6155 E HARRY, 67218 682-1754 3901550637 29 M 3901 55 FP
KLONIS D O,DEMOSTHENIS, 551 N HILLSIDE #410, 67214 684-3838 4878830321 55 M 4878 CD	LEISY MD,JERALD W, 3310 E DOUGLAS STE 101, 67208 681-2937 1902680582 42 M 1902 70 P
KLUZAK MD,THOMAS R, 550 N HILLSIDE, 67214 688-7107 1643741870 49 M 1643 88 PATH	LEITNER MD,YORAM B, 3311 E MURDOCK, 67208 689-9227 3519770821 53 M 3519 82 OT0
KNAPP MD,LESLIE E, 4700 W 13TH STE 106, 67212 1902250073 96 M 1902 25 OO	LESKO MO,PAUL D, PO BOX 407, 67201 264-9225 5605790820 49 M 5605 ORS
KNAPP MO,M ROBERT, 810 N LORRAINE, 67214 685-2207 3519470615 23 M 3519 55 AN	LEU MD,RICHARD H, 925 N EMPORIA, 67214 268-5996 1803740697 48 M 1803 89 FP
KNEIDEL MD,THOMAS W, 1111 N ST FRANCIS, 67214 267-1924 4101660562 40 M 4101 70 ORS	LEVINE MD,WILLIAM R, 8911 E ORME, 67207 686-5151 1902670561 42 M 1902 68 P
KNIGHT MO,LAURA C, 929 N ST FRANCIS, 67214 268-5912 502680188 42 F 502 OR	LIES MO,RICHARD B, 3311 E MURDOCK, 67208 689-9131 1902680604 42 M 1902 69 RHU

LIN MO, JOE J, 929 N ST FRANCIS, 67214
 268-5420 24404690112
 42 M 24404 72 PATH

LINO HOLM MD, DWIGHT L, 3333 E CENTRAL STE 602, 67208
 651-0033 1902781044
 53 M 1902 89 PDN

LINHAROT MO, RONALD D, 1035 N EMPORIA #290, 67214
 264-6267 2803640320
 36 M 2803 68 OBG

LIPMAN MD, RANDEE E, 3311 E MURDOCK, 67208
 689-9111
 56 F 64954 91 CO

LITTELL MD, JAMES A, 929 N ST FRANCIS RMC, 67214
 268-5048 1902711305
 44 M 1902 72 EM

LIVINGSTON O.O., DOUGLAS R, 551 N HILLSIDE #410, 67214
 684-3838 2879770486
 52 M 2879 78 PUO

LOEFFLER MD, JAMES A, 400 N WOODLAWN STE 109, 67208
 685-5375 3841630458
 36 M 3841 68 A

LOEWEN MO, WILLIAM C, 8200 W CENTRAL STE 1, 67212
 721-4544 1902711275
 41 M 1902 72 FP

LOHNES JR MD, JOHN H, 3333 E CENTRAL #214, 67208
 685-1291 1803820984
 55 M 1803 72 DR

LOSEE MD, JOHN M, 1650 S GEORGETOWN ST K #200, 67218
 686-7327 43D1770711
 51 M 4301 82 AN

LOVETT MD, PAUL A, 110 PATTON, 67208
 1902450391
 09 M 1902 45 00

LOW MO, HAROLO L, 2481 COOLIDGE, 67204
 1902440891
 18 M 1902 44 00

LUCAS MO, GEORGE L, 3311 E MURDOCK, 67208
 689-9495 1001610542
 34 M 1001 84 ORS

LUCKERDTH MD, LEAH L, 3243 E MURDOCK STE 500, 67208
 684-0251 1902861111
 58 F 1902 87 IM

LUDLOW MD, MICHAEL G, 8200 W CENTRAL STE 1, 67212
 721-4544 1902821054
 56 M 1902 85 FP

LUEKEN MD, LUEKE B, 3311 E MURDOCK, 67208
 689-9234 4072352011D
 23 M 40723 63 OBG

LUTZ MD, RICHARD E, 550 N HILLSIDE, 67208
 688-2360 1902841179
 55 M 1902 88 PD

LYGRISSE MD, DANIEL V, 3311 E MURDOCK, 67208
 689-9107 64914782838
 50 M 64914 82 FP

LYNCH MD, MARY A, 320 N HILLSIDE, 67214
 682-3221 1002772147
 48 F 1002 81 FP

MAGIDSON MD, ELLIOTT ARTHUR, 116 LONGFORD CT, 67206
 689-9272 1611681166
 43 M 1611 21 PATH

MAILMAN MO, GERSHOM, PO BOX 20467, 67208
 3519530791
 26 M 3519 57 00

MANASCO MD, RONALD R, 1650 S GEORGETOWN ST K #200, 67218
 686-7327 512830846
 52 M 512 84 AN

MANOELBAUM MO, MARK A, PO BOX 47668, 67201
 684-3838 3901791057
 53 M 3901 83 N

MANNING MO, ROBERT T, UKSM WICHITA 1010 N KANSAS, 67214
 261-2650 1902540586
 27 M 1902 54 IM

MARBACH MO, JAMES C, 3600 E HARRY, 67218
 689-5043
 57 M 4804 90 FP

MARSH MO, CONNIE M, 1035 N EMPORIA STE 130, 67214
 264-3222 1902752362
 47 F 1902 78 P

MARSH MO, HENRY O, 905 N EMPORIA BOX 3298, 67201
 262-7598 1611431721
 18 M 1611 46 ORS

MARTIN JR MO, GLEN E, 624 LONGFORD LANE, 67206
 1902490457
 20 M 1902 49 OD

MARTIN MD, RONALD L, UKSM - WICHITA 1010 N KANSAS, 67214
 261-2647 1606710824
 45 M 1606 80 P

MARYMONT JR MD, JESSE H, WESLEY MEO CNTR 550 N HILLSIDE, 67214
 688-2847 3515540368
 28 M 3515 64 PATH

MASTID JR MO, GEORGE J, 3243 E MURDOCK LEVEL G #12, 67208
 684-5235 1902520470
 25 M 1902 52 GS

MATASSARIN MD, BENJAMIN M, 551 N HILLSIDE #410, 67214
 684-5243 1902450412
 20 M 1902 45 IM

MATASSARIN MD, FREDERICK W, 743 N EMPORIA, 67214
 265-2382 190237D397
 15 M 1902 37 U

MAURICIO MD, DENNY G, 2456 N WOODLAWN, 67220
 685-1382 1401850836
 54 M 87 FP

MAWDSLEY MO, MICHAEL W, 1010 N KANSAS, 67214
 261-2622 1902741662
 49 M 1902 75 PD

MCBOYLE MD, MARILEE, 818 N EMPORIA STE 200, 67214
 263-0296 190277D867
 52 F 1902 78 GS

MCCLANAHAN MO, WARO A, 1515 S CLIFTON STE 130, 67218
 684-8211 3005480409
 22 M 3005 49 ORS

MCCLELLAN MD, ERNEST L, 1650 S GEORGETOWN ST K #200, 67218
 686-7327 4802700895
 38 M 4802 73 AN

MCCOY MD, C PATRICK, 1650 S GEORGETOWN ST K #200, 67218
 686-7327 1902791261
 53 M 1902 83 AN

MCCOY MO, CHARLES P, 1211 RUTLAND, 67206
 3006420302
 17 M 3006 42 00

MCOONOUGH MO, W DAVIO, 3311 E MURDOCK, 67208
 689-9239 3305761337
 48 M 3305 82 U

MCGUIRE MO, WILLIAM F, 8725 STONERIDGE, 67206
 4101431601
 17 M 4101 49 DO

MCGUIRE, CHARLES W, 3333 E CENTRAL STE 214, 67208
 685-1291 1803841124
 57 M 1803 84 DR

MCINNIS MD, OALTON B, 2405 E PAWNEE, 67211
 685-2153
 45 M 3901 88 FP

MCKAY MD, ROBERT S, PO BOX 782438, 67278
 685-4389 3901831067
 56 M 3901 84 AN

MCMASTER MD, JOHN F, 315 N HILLSIDE #8, 67214
 681-0423 2106821146
 54 M 2106 83 FP

MCMULLEN MO, BRUCE R, 1122 S CLIFTON, 67218
 682-5012 40D279D713
 53 M 40D2 80 IM

MCNICKLE MD,GEORGE A, 222 S RIDGE RO, 67209 945-0142 1902750742 49 M 1902 FP	MILLER MD,ROGER M, 1431 S BLUFFVIEW STE 205, 67218 788-6270 4102630888 37 M 4102 83 8L8
MCQUEEN MD,OAVIO ARNOLD, 905 N EMPORIA BOX 3298, 67201 262-7598 64914750138 47 M 64914 77 ORS	MILLER MD,TODO A, 820D W CENTRAL STE 1, 67212 721-4544 1902810559 55 M 1902 82 FP
MEANS MD,MILA LEE, 818 CARRIAGE PKWY, 67208 685-8231 1902821232 56 F 1902 83 FP	MILLS MD,CHARLES D, 1140 S WATER, 67213 2002140112 89 M 2002 16 00
MEEK JR MD,JOSEPH C, UKSM-WICHITA 1010 N KANSAS, 67214 261-2600 1902570582 31 M 1902 57 IM	MILLS MO,PHILIP R, 2501 E CENTRAL, 67214 683-6613 512751938 49 M 512 PM
MEEKER II MD,8RUCE P, 345 N HILLSIDE, 67214 686-3384 1902580626 30 M 1902 59 OBG	MINNS MO,GAROLO O, UKSM-WICHITA 1010 N KANSAS, 67214 261-2650 1902760969 51 M 1902 77 IM
MEISEL JR MO,RICHARD L, 550 N HILLSIDE, 67214 688-2072 53 M 1902 84 DBG	MIRANOA MO,JOSEPH R, 3311 E MURDOCK, 67208 689-9422 4812791155 52 M 4812 OR
MELEAN MD,JAIME, 1152 S CLIFTON, 67218 688-0321 17602670015 40 M 17602 78 CD	MOELLER MD,CHRISTOPHER A, 835 N HILLSIDE, 67214 685-4395 1803831137 55 M 1803 87 D
MELHORN MD,J MARK, 1111 N ST FRANCIS, 67214 267-1924 1902791317 53 M 1902 82 ORS	MONTGOMERYSHORT MD,RUTH G, 1019 W 50TH NORTH, 67204 1902370435 10 F 1902 37 00
MELHORN MO,KATHERINE J, 3243 E MURDOCK LEVEL A, 67208 688-3110 1902810532 55 F 1902 83 PD	MOORE MD,DENNIS F, 3311 E MURDOCK, 67208 689-9250 2101620878 36 M 2101 64 HEM
MENAKER MO,JEROME S, 2703 E CENTRAL, 67214 685-1227 1002410423 16 M 1002 49 DBG	MORGAN III MO,LOUIS S, 8030 E KELLOGG, 67207 683-3811 3901480353 22 M 3901 49 FP
MENOIONES MD,L MARLENE, 2501 E CENTRAL, 67214 687-5733 1611701078 45 F 1611 75 D	MORGAN MD,DICK A, 1650 S GEORGETOWN ST K #200, 67218 686-7327 3901690641 43 M 3901 AN
MENEHAN MO,H JAMES, 9006 PEPPERTREE CIR, 67226 1902530581 26 M 1902 53 OD	MORGAN MO,JAMES I, PO BOX 17007, 67217 522-2266 1606530834 29 M 1606 56 FP
MENKING MO,F W MANFRED, 3311 E MURDOCK, 67208 689-9336 40715610037 34 M 40715 74 PD	MORGAN MD,RANDALL J, 345 N HILLSIDE, 67214 682-4572 1902770999 52 M 1902 08G
MENKING MD,SUSAN MARGARET, UKSM WICHITA 1010 N KANSAS, 67214 261-2631 3840671461 41 F 3840 77 PD	MORRISON MO,RICHARD L, 1148 S HILLSIDE STE 102, 67211 684-3391 1902670676 42 M 1902 68 FP
MERCADER MD,MARIO S, 1650 S GEORGETOWN ST K #200, 67218 686-7327 74801690151 43 M 74801 78 AN	MORROW MO,THOMAS F, 3310 E DOUGLAS, 67208 685-1443 5606460980 21 M 5606 51 P
MEREDITH MO,W TOM, 1035 N EMPORIA STE 105, 67214 263-7285 4812610681 35 M 4812 69 IM	MOSER MD,SCOTT E, 3243 E MURDOCK STE 303, 67208 688-3070 55 M 4804 87 FP
MERRIFIELD MO,TERRY S, 818 CARRIAGE PKWY, 67208 685-8231 1002751221 47 F 1002 76 FP	MOSIER MD,STANLEY JAY, 818 CARRIAGE PKWY, 67208 685-8231 1902680701 42 M 1902 69 FP
MERSHON MD,JAMES C, PO BOX 2517, 67201 263-5889 1803630727 37 M 1803 70 CO	MROZ MD,MARY K, 3243 E MURDOCK #303, 67208 688-3070 1846810440 57 F 2846 87 FP
MESSAMORE MO,OEERA L, 551 N HILLSIDE STE 540, 67214 685-7234 1902841250 58 F 1902 08G	MUELLER MD,MICHAEL A, 1650 S GEORGETOWN ST K #200, 67218 686-7327 1902861242 60 M 1902 89 AN
MESSNER MD,STAN A, 820D W CENTRAL, 67212 721-4544 1902831262 56 M 1902 84 FP	MUETH COUPLAND MD,JOAN O, 7111 E 21ST, 67206 684-2851 2803790801 53 F 2803 80 FP
MEYER MO,WARREN E, 130 BRENDONWOOD, 67207 1606511139 27 M 1606 58 00	MULLINIX MD,JANICE M, 3311 E MURDOCK, 67208 689-9137 2802731089 47 F 3006 77 N
MICHELBAACH MD,ALBERT P, 4815 E CENTRAL, 67208 684-4750 2101610643 35 M 2101 66 IM	MURPHY MO,BARRY L, 3243 E MURDOCK STE 500, 67208 684-0251 1902710767 45 M 1902 72 IM
MILFELO MD,DOUGLAS J, 818 N EMPORIA STE 200, 67214 263-0296 4804720443 45 M 4804 79 TS	MURPHY MO,OUANE A, 3243 E MURDOCK STE 200, 67208 685-1491 1902650659 32 M 1902 66 ORS
MILLER MD,DAVID PATERSON, 7111 E 21ST, 67206 684-2851 2803770649 50 M 2803 78 FP	MURPHY MO,PATRICK L, 7150 E HARRY, 67207 687-2651 3901811198 55 M 3901 82 FP

MURPHY MD, PAUL M, 36DD E HARRY, 67218
689-5050 300651D492
28 M 3006 57 R

MURPHY MD, PAUL W, 8911 E ORME, 67207
686-5151 1902821348
49 M 1902 83 P

MURPHY MD, WILLIAM R C, 818 N EMPORIA STE 20D, 67214
263-0296 16D2680441
43 M 1611 TS

MURRAY MD, KENT B, VA MED CTR 5500 E KELLOGG, 67218
685-2221 390173D872
47 M 3901 74 IM

MURROW MD, RICHARD W, 3243 E MURDOCK STE 500, 672D8
685-2561 1902851280
57 M 1902 86 N

NELLIS MD, STEPHANIE F, 3311 E MURDOCK, 67208
689-9270 1902790744
53 F 1902 81 IM

NELSON JR MD, GUST H, 9127 AUTUMN CHASE, 67206
1902460426
23 M 1902 46 00

NELSON MD, GERALD D, 825 N HILLSIDE, 67214
688-7500 190260D601
34 M 1902 61 PS

NELSON MD, RUSSELL ALAN, 550 N HILLSIDE, 67214
688-2360 1902450510
18 M 1902 45 PO

NESMITH MD, LESLIE W, 530 N LORRAINE STE 100, 67214
683-5611 19D266D760
40 M 1902 67 OPH

NETHERTON MD, DAVID M, 315 N HILLSIDE STE A, 67214
686-3391 28D3810748
55 M 2803 82 FP

NEWBY MD, JAMES P, 818 N EMPORIA STE 200, 67214
263-0296 1902590656
34 M 1902 70 TS

NEWSOM MD, F CARTER, 331D E DOUGLAS, 672D8
685-1443 12D1430549
18 M 12D1 50 P

NIELSEN MD, MARY L, 3333 E CENTRAL STE 721, 67208
681-2741 1902771081
47 F 1902 78 PATH

NISLY MD, JANA L, 1611 N MOSLEY, 67214
263-7455 1902851352
58 F 1902 88 FP

NIXON MD, WILLIAM A, 2916 MENLO, 67211
1902441111
16 M 1902 44 00

NORMAN MD, BENJAMIN R, 2757 S SENECA, 67217
264-5182 1902851361
56 M 1902 86 FP

NORRIS MD, ROBERT P, 8649 E CHERRY CREEK CT, 67207
19D2430594
17 M 19D2 43 00

NDRTH MD, DORIS G, 1148 S HILLSIDE, 67211
684-5257 19D2470413
16 F 1902 47 FP

NDRTON MD, ROBERT K, 3311 E MURDOCK, 67208
689-9235 1001570702
32 M 1D01 67 PD

O'DONNELL JR MD, LEONARD A, 32 NDRFOLK, 67208
19D255D883
27 M 1902 55 00

OCHSNER MD, BRUCE B, 11DD N TDEKA, 67214
263-6273 1902650667
39 M 1902 66 DPH

ODENHEIMER MD, BURTRAM J, 3311 E MURDOCK, 67208
689-9137 2105731D11
48 M 2105 73 N

OLMSTEAD MD, CALVIN G, 818 N EMPORIA STE 411, 67214
268-6856 60D2790139
50 M 6D02 84 N

OLSON MD, DAN E, UKSM - WICHITA 1010 N KANSAS, 67214
261-2650 702731321
42 M 702 85 PM

ORTH-BALMAN MD, DIANE M, 222 S RIDGE RD, 67209
945-5400 19D2821402
56 F 1902 83 PD

OSBORNE MD, CONRAD C, 855 N HILLSIDE, 67214
685-1381 1902670714
38 M 1902 68 FP

OSIO MD, ANTONIO L, 4127 E KELLOGG, 67218
689-8677 26404660097
41 M 26404 72 EM

OSOBA MD, WILLIAM G, 2208 W 13TH ST N, 67203
943-9391 2802510635
25 M 2802 54 FP

OSTER MD, JOYCE A, 3311 E MURDOCK, 67208
689-9422 1902791422
54 F 1902 8D OR

OUANO JR MD, BIBIANO B, 1431 BLUFFVIEW ST #102, 67218
684-5094 748D1634391
40 M 74801 79 U

OWEN MD, LARUE W, 236 N BELMONT, 67208
1902500517
19 M 1902 50 00

OWEN MD, PERE A, 118D S CLIFTON AVE, 67218
681-2108 190264070D
37 M 1902 65 AN

DXLEY MD, DWIGHT K, 550 N HILLSIDE, 67214
688-2810 190262D644
36 M 19D2 63 PATH

PAGE MD, RUTH, 1051 N STRATFORD, 672D6
1902430616
13 F 1902 43 00

PALKE MD, WILLIAM M, 707 N MAIN, 672D3
582-4472 411482D682
56 M 4114 87 BLB

PALMER MD, DAVID L, PD BDX 945D, 67277
722-9132 19D2630631
37 M 1902 64 A

PALTAN JR MD, JOSE D, 2243 BRAMBLEWOOD APT 7D4, 67226
268-5413 4090578D036
48 M 84711 87 PATH

PANKOW MD, KIMBERLY J, 2939 N ROCK RD S-1DD, 67226
636-4344 1902832153
55 F 1902 85 P

PANKOW MD, LARRY M, 2939 N ROCK RD #1D0, 67226
265-8872 1902831424
49 M 1902 85 P

PARKER MD, HAROLD L, 7D27 FARMVIEW CT, 67206
1902670731
32 M 1902 68 D0

PARMAN MD, CRAIG R, 2757 S SENECA, 67217
264-5182 19028414D3
56 M 1902 87 FP

PASSMAN MD, STEVEN M, 835 N HILLSIDE, 67214
685-4395 28D373D671
47 M 28D3 83 D

PATTON MD, J MICHAEL, 2535 E LINCOLN, 67211
686-2111 3DD5780941
51 M 3005 79 FP

PAXTON MD, EDWARD SCOTT, 3600 E HARRY, 67218
689-5672 28D277D815
51 M 2802 83 PATH

PAY MD, NORMAN T, 929 N ST FRANCIS, 67214
268-5914 748D2680191
45 M 748D2 77 NR

PEERY MD, WILLIAM H, UKSM WICHITA 1D1D N KANSAS, 67214
261-265D 48D27311D3
46 M 48D2 82 IM

PEIL MD, MICHAEL L, 1D35 N EMPORIA #265, 67214
269-4026 19D28D0847
54 M 19D2 81 PM

PELLETIER JR MD,LAWRENCE L, 5500 E KELLDGG, 67218
 651-3654 3501680841
 42 M 3501 71 IM
 PENCE MO,CHARLES D, 3311 E MURDDCK, 67208
 689-9468 1902680779
 42 M 1902 69 ORS
 PENNER MO,STEVEN D, 855 N HILLSIDE, 67214
 685-1381 1902831441
 55 M 1902 86 FP
 PENNINGTON MD,KATHERINE, 2113 S BLUFF CT, 67218
 1902430641
 16 F 1902 43 00
 PERALES MD,MERCEDES, 1D35 N EMPDRIA STE 130, 67214
 264-3222 4934810081
 57 F 85 P
 PETERIE MD,JERRY D, 818 N EMPORIA STE 3D5, 67214
 264-3505 1902752559
 48 M 1902 76 IM
 PETERS MD,THOMAS J, 3311 N MURDOCK, 672D8
 689-9190 2803770762
 47 M 2803 79 IM
 PHILLIPS MD,DENNIS G, 1969 W 21ST ST, 672D3
 832-9024 1902851409
 58 M 1902 89 FP
 PHIPPS MD,JACK G, 117 BRENDENWODD CT, 672D6
 1902530661
 21 M 1902 53 OD
 PIBURN MD,MARVIN F, 125 N ZELTA, 67206
 1803480377
 22 M 1803 80 DO
 PICKERT MD,CURTIS B, 3311 E MURDOCK, 67208
 689-91D9 1902841446
 57 M 1902 85 PD
 PINSKER MD,JACOB A, 556 BROADMOOR CT, 67206
 1902350345
 06 M 1902 35 00
 PLAVAC MD,THDMAS, 551 N HILLSIDE #410, 67214
 684-3838 1102810976
 51 M 1102 88 IM
 POLINER MD,LAWRENCE R, 551 N HILLSIDE #41D, 67214
 684-3838 3520690611
 43 M 352D 83 CO
 POLING MD,TERRY L, 7602 E HARRY, 672D7
 682-7411 1902620717
 36 M 1902 63 FP
 POLLMAN MO,STANLEY E, 3600 E HARRY, 67218
 689-5668
 30 M 3007 84 PATH
 POLLOCK MD,ANTHONY G A, 825 N EMPORIA, 67214
 264-2806 91905710023
 45 M 80305 76 ORS
 POOLE MD,BERNARD T, 825 N EMPORIA, 67214
 264-2806 53902620318
 37 M 53902 73 ORS
 PORTER MD,GARRY L, 1148 S HILLSIDE #1D4, 67211
 686-7351 160661D927
 35 M 1606 63 P
 PORTER MO,MICHAEL G, 1515 S CLIFTON STE 31D, 67218
 686-1991 1902851433
 59 M 1902 85 GS
 POWERS MD,K DEAN, 27D3 E CENTRAL, 67214
 683-8386 1902470472
 23 M 1902 47 GYN
 PRESKORN MD,SHELOON H, 929 N ST FRANCIS, 67214
 268-5000 1902740879
 48 M 1902 75 P
 PURINTON MD,LEW W, 1431 S BLUFFVIEW DR STE 109, 67218
 685-3D30 190248D371
 23 M 1902 48 IM
 RADOVANDV MD,RADMILA, PD BOX 780446, 67278
 683-1243 957026D0082
 34 F 95702 72 R

RAGHAVAN MD,PARULA P, 1035 N EMPORIA STE 245, 67214
 262-7662 49501710783
 47 F 49501 80 IM
 RAGHAVAN MD,PRAKASH V, 1035 N EMPORIA #245, 67214
 262-7662 49501701091
 46 M 49501 80 CD
 RAMANNA MD,MAGENORA, 550D E KELLOGG, 67218
 685-2221
 56 M 49573 89 IM
 RANDALL MD,GEORGE R, 31D S HILLSIDE, 67211
 684-2838 2802690617
 43 M 2802 77 DTO
 RAUSA JR MD,FRANCISCO C, 1148 S HILLSIDE, 67211
 682-4535 74810660264
 42 M 74808 76 IM
 RAWCLIFFE JR MO,RDBERT A, 1111 N ST FRANCIS, 67214
 267-1924 35D1550778
 29 M 3501 63 ORS
 RAZEK MD,HANA A, 929 N ST FRANCIS, 67214
 268-6142 915D471D217
 47 F 33004 PATH
 RAZEK MD,ZACK A, 818 N EMPDRIA STE 200, 67214
 263-0296 605D1700242
 46 M 6D5D1 77 CDTs
 READER MD,G WHITNEY, 933 N TOPEKA, 67214
 263-5889 21D1751492
 48 M 2101 81 CD
 REALS MD,WILLIAM J, UKSM WICHITA 1010 N KANSAS, 67214
 261-2600 30D6450422
 20 M 30D6 46 PATH
 REAZIN MD,WALTER L, 855 N HILLSIDE, 67214
 685-1381 1902580740
 30 M 1902 59 FP
 REODI MD,RAGHUNATH P, 36D0 E HARRY, 67218
 689-5043 49521640226
 36 M 49521 80 RT
 REED MD,A J, 2456 N WOODLAWN, 67220
 685-5691 39016507D4
 4D M 3901 67 EM
 REED MD,D CRAMER, 752D E 21ST #22, 67226
 2802410703
 15 M 2802 46 00
 REED MD,DAVID D, 3333 E CENTRAL STE 214, 672D8
 685-1291 19D2690880
 43 M 1902 70 DR
 REED MD,WILLIAM RANDALL, 550 N HILLSIDE, 67214
 688-2360 1611772145
 51 M 1611 83 NPM
 REISMAN MD,MICHAEL ALAN, 201 S HILLSIDE ST, 67211
 683-5688 4804752574
 50 M 4804 76 DPH
 REISWIG MD,JEFFREY S, 8200 W CENTRAL STE 1, 67212
 721-4544 1902861382
 60 M 1902 87 FP
 RELIHAN MD,DONALD A, 655 N WOODLAWN, 672D8
 684-5158 1902540799
 27 M 1902 54 OPH
 REMPEL MD,JOHN H, 1515 S CLIFTON STE 24D, 67218
 685-1812 390162D660
 38 M 3901 7D PS
 REYNOLDS MD,TERESA A, 3311 E MURDOCK, 67208
 689-94D0 190281D648
 52 F 1902 88 IM
 RHODEN MD,CURTIS H, 3243 E MURDOCK STE 5D0, 67208
 684-0251 1606590985
 33 M 1606 67 IM
 RHDDDES MD,IVAN E, 144 S HILLSIDE, 67211
 685-9289 3901490383
 25 M 3901 56 R
 RHDDDES MD,LOWELL M, 315 N HILLSIDE STE C, 67214
 685-1461 1902530742
 25 M 1902 53 FP

RIEGER MD, ERNEST H, 5922 POLD DR, 67208 190256096D 29 M 1902 56 DD	SA80DR MD, SYED A, 1725 E DDUGLAS, 67211 264-8989 4952D610234 35 M 4952D P
RIGGS MD, KAY R, 3236 N RDCK RD STE 19D, 67226 634-12DD 1902881961 54 F 1902 89 PD	SACK MD, JOSEPH M, 7111 E 21ST, 672D6 684-2851 1902871515 6D M 1902 88 FP
RIORDAN MD, HUGH D, 3100 N HILLSIDE, 67219 682-31DD 56D5570579 32 M 56D5 59 P	SADIQ MD, SULEMAN, 1144 N ST FRANCIS, 67214 267-D159 704D163D161 4D M 7D4D1 74 TS
RIVERA D D, DARLA K, 7111 E 21ST, 67216 684-2851 287887D479 61 F 2878 89 FP	SANCHEZ MD, JDSE J, 3311 E MURDOCK, 672D8 689-9287 1643811479 54 M 1643 87 PD
ROACH MD, NEIL E, CHARTER HDSP 8901 E ORME, 672D7 686-51D8 190267D82D 38 M 1902 68 P	SANTDS MD, JDAQUIN G, 3243 E MURDDCK STE 50D, 672D8 684-D251 1902810672 49 M 1902 81 IM
RDAN MD, YEA1, 55D N HILLSIDE, 67214 688-236D 385D167DD62 41 M 385D1 82 PD	SANTDSCDY MD, GILBERT S, 3311 E MURDDCK, 67208 689-9124 481262D776 38 M 4812 7D GS
ROBERTS D D, RDGER W, PO 8DX 47668, 672D1 264-8604 2879750230 49 M 2879 78 CD	SCANLAN MD, TIMDTHY M, 36DD E HARRY, 67218 689-485D 26D4711358 46 M 2604 78 FP
RDERTS MD, DANIEL K, 551 N HILLSIDE STE 540, 67214 685-7234 3DD561D582 36 M 3D05 71 D8G	SCHEIN8ERG MD, KENNETH, 3311 E MURDDCK, 672D8 689-9111 42 M 1642 ENT
RDERTSDN MD, JDSEPH K, 818 N EMPDRIA STE 20D, 67214 263-D296 39D166D793 41 M 39D1 68 GS	SCHLACHTER MD, ERNEST R, 4D6 E CENTRAL, 672D2 265-D7D5 19D2520569 24 M 1902 52 FP
RD8INSDN MD, G DONALD, 3333 E CENTRAL STE 61D, 672D8 686-6659 19D254D811 28 M 1902 54 PD	SCHLAGECK MD, JDSEPH G, 820D W CENTRAL S - 1, 67212 721-4544 19D2821691 55 M 1902 85 FP
RO8INSDN MD, ROBERT H, 558 N STRATFORD, 672D6 190253D769 2D M 1902 53 DD	SCHLICHER MD, JDHN E, 3311 E MURDOCK, 672D8 689-9344 180366D936 40 M 18D3 72 D
RD8L MD, DAVID A, 82DD W CENTRAL STE 1, 67212 721-4544 19027422D1 48 M 1902 76 FP	SCHLUETER MD, JDHN J, 144 S HILLSIDE, 67211 685-9289 3841560654 31 M 3841 62 R
RODRIGUEZTOCKER MD, LILIA, 225 PENROSE, 672D6 275D149D402 21 F 275D1 57 00	SCHNEIOER MD, SETH A, 2627 E CENTRAL, 67214 684-0501 1642770779 53 M 1642 80 A
ROMALIS MO, BRIAN E, 1431 S 8LUFFVIEW STE 203, 67218 682-5D69 62D1630086 39 M 6201 73 P	SCHNELLE MD, JOACHIM, 4145 E KELLOGG, 67218 682-6551 40933700030 44 M 40933 73 FP
ROOS MD, MAUREEN, 925 N EMPDRIA, 67214 265-2876 1902781583 53 F 1902 80 FP	SCHOPF MO, CLIFTON C, 222 S RIOGE RD, 67209 945-0142 1902570779 29 M 1902 57 FP
ROSE MD, SHEL8Y O, 3333 E CENTRAL STE 721, 67208 681-2741 2D12680476 40 M 2012 71 PATH	SCHWARTZ MO, V DEAN, 335 WHITFIELD PL, 67206 1902480401 24 M 1902 48 00
RDSE8RAUGH MD, CURTIS J, 5500 E KELLOGG, 67218 685-2221 1902861447 57 M 1902 89 IM	SCOTT MO, WILLIAM H, 1431 S 8LUFFVIEW STE 111, 67218 685-8262 4901650433 41 M 4901 73 CO
ROSEN MO, DAVID, 818 N EMPDRIA STE 105, 67214 265-3774 19D274095D 48 M 1902 75 PO	SEN SARMA MD, PRONA8 K, 1144 N ST FRANCIS, 67214 267-0159 49518670050 45 M 49518 81 CD
RDSEN8ERG MD, THDMAS F, 2627 E CENTRAL, 67214 684-05D1 1642680575 41 M 1642 72 A	SHAFFER MD, PRESTON J, 3788 RUSHWOOD CT, 67226 3005460653 20 M 3D05 47 00
ROSS IV MD, ALBERT M, 3311 E MURDOCK, 672D8 689-9160 58 M 1902 90 PD	SHAH MO, MUKHTAR H, 1725 E DDUGLAS, 67211 686-7351 7040464D150 40 M 7D404 77 P
ROSS MD, OENNIS LEE, 1035 N EMPORIA STE 105, 67214 263-7285 30D573D855 47 M 30D5 78 NEP	SHAPIRO MD, WILLIAM M, 818 N EMPORIA STE 304, 67214 263-0348 16D6761917 45 M 1606 84 NS
RUMISEK MO, JOHN D, 818 N EMPORIA STE 200, 67214 263-0296 4804752345 50 M 4804 CDTs	SHAW MO, RICHARD C, 825 N HILLSIDE, 67214 688-7500 190261072D 35 M 1902 62 PS
RUSSELL MD, PHILIP W, 3311 E MURDOCK, 67208 689-9351 19D2441294 22 M 1902 44 IM	SHELLITO MD, JOHN G, PD 80X 781774, 67278 1606431933 18 M 16D6 49 DD
SABIN JR MO, GEDRGE M, 6412 E 9TH, 67206 5002390304 12 M 5002 66 00	SHELLITD MO, JDHN L, 3311 E MURDOCK, 67208 689-9124 2407781271 52 M 2407 84 GS

SHIELO MO, CHARLES, 818 N EMPORIA STE 20D, 67214 263-0296 2802720851 46 M 2802 81 GS	STARK MD, JAMES R, 719 8ROOKFIELD RD, 67206 1902441472 20 M 1902 44 00
SHOFFNER MO, RICHARD W, 3311 E MURDOCK, 67208 689-9271 3901791405 53 M 3901 82 IM	STECKLEY MO, RICHARD ALLEN, PO BOX 47669, 67201 265-1308 2105741271 49 M 2105 80 IM
SHRAOER MO, C ERIC, 655 N WOODLAWN, 67208 684-5158 1902781702 47 M 1902 79 OPH	STEELBERG MO, ELSIE, 2939 N ROCK RD #100, 67226 265-8872 1606601171 34 F 1606 84 P
SHRAOER MD, DOYLE A, 119 N ARMOUR, 67206 1902410623 16 M 1902 41 00	STEIN MD, PAUL S, 551 N HILLSIDE #330, 67214 685-2377 3305660689 4D M 3305 73 NS
SHURTZ MO, GLEN L, 3333 E CENTRAL STE 214, 67208 685-1291 4802782298 40 M 4802 81 R	STEINBERGER MO, RICHARD E, 851 N HILLSIDE, 67214 685-1371 56120810036 53 M 56120 U
SIFFORD MD, R LAWRENCE, 959 N EMPORIA STE 305, 67214 265-0561 1803520611 25 M 1803 58 IM	STEMBRIDGE MO, TRAVIS W, 551 N HILLSIDE STE 54D, 67214 685-7234 4802761754 47 M 4802 78 08G
SIMMS MO, DAVIO ALAN, 3311 E MURDOCK, 67208 689-9422 3401760538 50 M 3401 83 OR	STEPHANZ JR MD, GERALD 8, 1035 N EMPORIA STE 105, 67214 263-7285 1902831734 57 M 1902 84 IM
SKI8BA MD, RICHARD M, 3311 E MURDOCK, 67208 689-9477 5606700891 43 M 5606 72 GE	STEVENS MO, WM. MICHAEL, 551 N HILLSIDE STE 540, 67214 685-7234 1902831751 55 M 1902 08G
SLUTSKY MO, LAWRENCE JOEL, 929 N ST FRANCIS, 67214 268-5922 3501721122 46 M 3501 79 OR	STREET MD, DAVIO E, 818 N EMPORIA STE 200, 67214 263-0296 2101611038 35 M 2101 67 GS
SMITH D O, JAMES A M, 551 N HILLSIDE #410, 67214 684-3838 50 M 4177 88 IM	STREIT MO, JEROME G, 1131 S CLIFTON, 67218 689-5500 1902771472 48 M 1902 78 FP
SMITH JR MO, WILLARD J, 8100 TIPPERARY, 67206 1602570581 32 M 1611 65 00	STRICKLAND MD, M H VAN, 7011 W CENTRAL STE 116, 67212 682-3100 4804742111 51 M 4804 A
SMITH MO, ALVIN L, 929 N ST FRANCIS, 67214 268-5470 5606570874 28 M 5606 72 PATH	SUERO MO, JESUS T, 1148 S HILLSIDE, 67211 681-3371 74802570655 33 M 74802 57 PUO
SMITH MD, LINDALL E, 3333 E CENTRAL STE 408, 67208 682-0411 1902821771 55 M 1902 PO	SULLIVAN MD, LEONARD L, 3311 E MURDOCK, 67208 689-9454 1902610789 35 M 1902 62 PO
SNYDER MD, GREGG M, 902 N HILLSIDE, 67214 687-1441 1803541023 27 M 1803 66 NS	SVOBODA MD, LOIS V, 818 CARRIAGE PKWY, 67208 685-8231 1602660784 39 F 1602 81 FP
SOLLO MD, DAVID G, 1650 S GEORGETOWN ST K #200, 67218 686-7327 4804841917 59 M 4804 89 AN	SVOBODA MO, WILLIAM 8, 1035 N EMPORIA #270, 67214 267-5215 1602630583 36 M 1602 81 PON
SOLLO MO, NATALIE R, 3333 E CENTRAL, 67208 682-0411 59 F 4804 89 PO	SWEET MD, OONNA E, UKSM WICHITA 1010 N KANSAS, 67214 261-2622 1902791813 48 F 1902 80 IM
SOLOMON MD, HERMAN, 835 N HILLSIDE, 67214 685-4395 2701620561 37 M 2701 69 O	TAN MO, DONALD C-S, 808 N EMPORIA, 67214 268-5908 512660924 34 M 512 89 RO
SOLTZ MD, ROBERT A, 3311 E MURDOCK, 67208 689-9320 2803740821 47 M 2803 77 PD	TARVER MO, STEPHEN D, 1650 S GEORGETOWN ST K #200, 67218 686-7327 1902851751 58 M 1902 AN
SOMERS MO, MARVIN M, 2506 BENJAMIN, 67204 190248D427 23 M 1902 48 OD	TATPATI MO, DANIEL A, 1144 N ST FRANCIS, 67214 267-0159 49535670039 44 M 49535 78 TS
SPANN MO, RICHARD W, 3243 E MURDOCK STE 500, 67208 684-0251 1902650870 4D M 1902 66 PUO	TATPATI MO, OLGA ADELINA, 1515 S CLIFTON STE 25D, 67218 687-31DD 49535640041 44 F 49535 78 PD
SPARKS MD, STEPHEN T, 2501 E CENTRAL, 67214 683-6613 512841198 56 M 512 89 OM	TAYLOR MO, STEVEN L, 3311 E MURDOCK, 67208 689-9422 1902771502 46 M 1902 78 R
SPEER MO, JAMES K, 3243 E MURDOCK STE 500, 67208 684-0251 3901821487 56 M 3901 90 IM	THAKOR MD, DENNIS S, 310 S HILLSIDE, 67211 684-2B38 2307821071 57 M 2307 87 OTO
SPRINGER MD, MARK J, 3311 E MURDOCK, 67208 689-9311 1902871612 61 M 1902 89 PO	THELEN MD, J CHRISTINE, 7373 E 29TH ST N APT 1123, 67226 5104370642 13 F 5104 50 00
STAMPS MO, PHIL, 3600 E HARRY, 67218 689-5668 39D1630746 37 M 3901 PATH	THOMAS MD, OARYL L, 2318 E CENTRAL, 67214 262-2415 1902821879 56 M 1902 86 IM

THOMPSON MO, DANIEL M, PO BOX 4069, 67204 838-3381 1902500746 19 M 1902 50 FP	VIERTHALER MO, LYLE O, 1650 S GEORGETOWN ST K #200, 67218 686-7327 1902801126 54 M 1902 81 AN
TILLER MO, GEORGE R, 5101 E KELLOGG, 67218 684-5255 1902670919 41 M 1902 68 AM	VIN ZANT MO, LARRY E, 13741 ST ANOREWS PL, 67230 1902400563 10 M 1902 40 00
TILTON MO, FREDERICK E, BOEING MILIT AIRPL PO BOX 7730, 672 526-0024 3401770614 40 M 3401 88 OM	VINE MO, DONALD LEE, 1010 N KANSAS, 67208 261-2622 511660564 39 M 511 79 CO
TINTEROW MO, MAURICE M, 641 N WOODLAWN #29, 67208 4802410706 17 M 4802 46 00	VINZANT MO, WHITNEY L, 1515 S CLIFTON AVE K #310, 67218 686-1991 1902711143 45 M 1902 74 GS
TOCKER MO, ALFREO M, 225 PENROSE, 67206 4802400808 15 M 4802 53 00	WAOE MO, EDWARD J, 818 N EMPORIA STE 101, 67214 263-1574 1902801142 53 M 1902 83 AN
TONN MO, GERHART R, 13600 E 37TH ST N, 67228 1902441529 16 M 1902 44 00	WAOUO MO, ABOUL, 1543 S HILLSIOE, 67211 682-6814 70409600059 35 M 70409 74 P
TOOHEY MO, JOHN S, 3311 E MURDOCK, 67208 689-9277 5605771388 50 M 5605 82 ORS	WAKEFIELD MO, KENNETH M, 1148 S HILLSIOE STE 105, 67211 686-4374 6201480122 24 M 6201 86 FP
TOSH MO, FRED E, 1900 E NINTH, 67214 268-8391 4706541590 30 M 4706 80 PH	WALKER O O, MARSHALL O, 982 N TYLER #0, 67212 722-5811 2878720124 41 M 2878 80 OTO
TRACY MO, TERRY A, 315 N HILLSIOE #B, 67214 681-0423 2803610579 35 M 2803 68 OBG	WALL MO, DAVIO M, 925 N EMPORIA, 67214 265-2876 4813781153 53 M 4813 87 FP
TREGO MO, A JASON, 8404 W 13TH #120, 67212 722-6000 1902842361 55 M 1902 IM	WALLING MO, AORIAN E, 2959 N ROCK RD, 67226 681-1152 80302710019 47 M 80302 78 FP
TRETBAR MO, HARVEY A, 3243 E MURDOCK #500, 67208 684-0251 1902520712 25 M 1902 52 IM	WALLING MO, ANNE O, UKSM WICHITA 1010 N KANSAS, 67214 261-2607 91902710031 47 F 80302 PH
TREWEEKE MO, MICHAEL W, 551 N HILLSIOE #410, 67214 684-3838 1902721157 46 M 1902 73 IM	WALSH O O, LESLIE L, 1650 S GEORGETOWN ST K #200, 67218 686-7327 2879820548 56 M 2879 AN
TROUTMAN O O, BETTY, 7717 E 29TH ST N, 67226 636-5585 2878870916 51 F 2878 FP	WARO MO, CYNTHIA L, 8100 E 22ND ST 8LOG 2200, 67226 683-4334 1902851875 58 F 1902 FP
TRUJILLO MO, ANTERO A, 1431 S BLUFFVIEW STE 117, 67218 685-6466 73701610218 36 M 73701 81 AN	WARO MO, LARRY G, 1650 S GEORGETOWN ST K #200, 67218 686-7327 1902791911 54 M 1902 82 AN
TRUONG O O, THANH N, 1144 N ST FRANCIS, 67214 267-1059 2878860198 57 M 2878 87 IM	WARREN JR MO, JOHN W, 63 VIA VEROE, 67230 2501390863 15 M 2501 49 00
TUCKER O O, DAVIO A, 7200 W 13TH, 67212 721-1200 2878850575 54 M 2878 86 FP	WARREN MO, LLOYD P, 1202 WILLOW LN, 67208 1902360570 11 M 1902 36 00
TURLEY MO, HAROLO M, 1520 S CLIFTON, 67218 689-5775 58 M 1902 90 FP	WARREN MD, WIRT A, 608 S BLUFF, 67218 2802330777 09 M 2802 36 00
UHLIG MO, PAUL J, 1342 ESTATE CT, 67208 1902570973 28 M 1902 57 00	WEAVER MO, JACK D, 1616 COOLIDGE, 67214 2802420865 16 M 2802 46 00
UHLIG MO, PAUL N, 3311 E MURDOCK, 67208 689-9111 1902781851 53 M 1902 COS	WEBB MO, DAVID E, 818 N EMPORIA STE 310, 67214 263-5891 53 M 1902 88 IM
VAL-MEJIAS MO, JESUS E, 551 N HILLSIOE #410, 67214 684-3838 23101690067 45 M 23101 84 CO	WEBER JR MO, HUGO P, 1035 N EMPORIA STE 105, 67214 263-7285 702660718 40 M 702 73 IM
VAN GALLERA MD, ROBERT, 3311 E MURDOCK, 67208 689-9107 1902841861 51 M 1902 FP	WEBSTER MO, BOBBY W, 2903 E CENTRAL, 67214 687-2112 4802742288 48 M 4802 75 OBG
VAN GEEM MO, THOMAS A, 818 N EMPORIA STE 415, 67214 269-4355 3006831051 54 M 502 89 OBG	WEIPPERT MO, EDWARD J, 8200 W CENTRAL #1, 67212 721-4544 1902701202 44 M 1902 71 FP
VARENHORST MO, MICHAEL P, 530 N LORAIN STE 100, 67214 683-5611 1803801599 52 M 1803 85 OPH	WELCH MO, LAUREN K, 551 N HILLSIOE #330, 67214 685-2377 1902610860 35 M 1902 62 N
VAUGHAN MO, O ANN, 8911 E ORME 1010 N KANSAS, 67207 686-5151 1902710601 45 F 1902 75 P	WENINGER MO, JOHN H, 1148 S HILLSIOE STE 12, 67211 682-6523 3005620693 32 M 3005 63 FP

WES8ROOK MD,C WILSON, 3311 E MUROOCK, 67208
689-9234 1902741247
42 M 1902 75 DBG

WEST MO,WILLIAM T, 3 ORURY LN, 67207
1902490724
24 M 1902 49 OD

WHEELER MD,NICKY RAY, 1515 S CLIFTON STE 390, 67218
684-0220 1902741255
48 M 1902 74 PS

WHEELER MD,PINCKNEY R, 2168 BELLA VISTA, 67203
3901560896
18 M 3901 57 00

WHITAKER MO,JAMES A, 3243 E MUROOCK STE 5DD, 67208
684-0251 1902721211
44 M 1902 74 IM

WHITE MO,CHARLES M, 18 VIA VEROE, 67230
3005410656
15 M 3005 48 00

WHITESIDE MO,WILLIAM H, 1431 S BLUFFVIEW S - 1D8, 67218
681-0086 53902720304
46 M 53903 84 PD

WILDER MD,LOWELL W, 655 N WOODLAWN, 67208
684-5158 4109620764
35 M 4109 67 OPH

WILES MD,DENNIS D, 3333 E CENTRAL STE 408, 67208
682-0411 1902841969
58 M 1902 PD

WILKINSON MO,LARRY K, 1520 S CLIFTON, 67218
689-5775 1902741859
46 M 1902 75 FP

WILLIAMS MO,CHARLES L, 554 N 8ROAOMOR CT, 67206
2834432024
16 M 2834 50 00

WILSON MD,ROBERT L, 841 N BROAOWAY, 67214
263-6131 1902571040
30 M 1902 57 DM

WINOHOLZ MD,ARTHUR F, 1969 W 21ST, 67203
832-9044 3901861705
61 M 3901 87 FP

WINN MO,TERRIA L, PO BOX 48126, 67201
265-7241 1902822000
56 F 1902 83 OPH

WISNER JR MD,HARRY J, 5642 COE DR, 67208
3005431394
17 M 3DD5 47 00

WITTMANN MO,ALBERT F, 555 SAGEBRUSH, 67230
2834380954
1D M 2834 40 00

WOLF MD,PATRICK G, 1431 S BLUFFVIEW DR STE 109, 67218
685-3030 1902771634
52 M 1902 78 IM

WOLFE MD,FREDERICK, 1035 N EMPORIA #230, 67214
263-2125 3508661532
36 M 3508 69 RHU

WOOD MD,GARY 8, 8527 BOXTHORN, 67226
2802450993
21 M 2802 51 00

WOOD MD,RDBERT O, 1441 N ROCK RD STE 1D01, 67206
1902530963
26 M 1902 53 00

WOODHOUSE MO,CHARLES L, 46 ST CLOUD PL, 67230
1902340561
10 M 1902 34 00

WDODRING MD,CATHY S, 222 S RIDGE RO, 67209
945-0142 3546771708
51 F 3546 82 FP

WRAY JR MD,REGINALD P, PO BOX 782438, 67278
685-4389 4113661289
40 M 4113 84 AN

WRAY MD,ALEXANDER J, 109 S SOCORA, 67212
943-2118 19D2490783
19 M 1902 49 FP

WRIGHT MD,STANLEY E, 2219 8ROMFIELD CIR, 67226
3901741351
47 M 3901 75 00

WU MD,JIN-TZE, 3333 E CENTRAL SUITE 214, 67208
685-1291 244D2670203
41 M 38502 79 TR

WYATT-HARRIS MD,PATRICIA G, 3333 E CENTRAL #504, 67208
683-6766 1902810851
55 F 1902 82 08G

YOON MD,CHANG SUP, BOX 782438, 67278
685-4389 58303720241
46 M 583D3 81 AN

YOUNG MO,DOUGLAS L, 3311 E MURDDCK, 67208
689-9213 1902711259
42 M 1902 72 IM

YOUNG MD,RDBERT C, PD BOX 782438, 67278
685-4389 1902852260
46 M 1902 9D AN

YOUNGBERG MD,OEAN I, 959 N EMPORIA #2D1, 67214
268-6D75 1902721254
00 M 1902 73 IM

YOUNGMAN DO,DARRELL J, 1035 N EMPORIA #210, 67214
265-1308 4878790087
52 M 4878 88 CD

ZARNOW MD,HILARY, 929 N ST FRANCIS, 67214
268-5905 1611691994
45 M 1611 74 R

ZATZKIN MD,JAY B, 818 N EMPORIA STE 4D3, 67214
262-4467 2002741221
46 M 20D2 79 IM

ZEPICK MO,LYLE F, PO BOX 2517, 672D1
263-5889 6002740D93
50 M 6001 81 CD

ZIEGLER MD,MARK L, 55D N HILLSIDE, 67214
688-2360
56 M 3901 88 NPM

ZIELKE MD,STEVEN L, 223 S HILLSIOE, 67211
683-2666 16438214D7
53 M 1643 82 08G

ZIMMERMAN MD,KENNETH O, 934 CRESTLINE, 67212
526-3925 3901550998
29 M 3901 58 OM

ZONGKER MD,PHILIP E, 3311 E MUROCK, 67208
689-9422 19D2701261
43 M 1902 71 R

ZWIACHER MD,KAYE, 1725 E DOUGLAS, 67211
264-8989
00 M P

WINCHESTER — 913 (Shawnee County Medical Society)

HUSTON MD,FRANCIS W, PO BOX H, 66097
16D134D638
06 M 1601 34 DD

WINFIELD — 316 (Cowley County Medical Society)

BHARGAVA MD,8AIKUNTH N, 1317 WHEAT RO, 67156
221-3200 4953D640441
37 M 4953D 78 U

JOHNSON MD,TERESA F, 1317 WHEAT RD, 67156
221-3200 19D281D982
55 F 1902 82 GS

KAUFMAN MD,LELAND R, PO 80X 643, 67156
221-3350 1902610428
33 M 19D2 61 FP

KAUL MD, ANANO N, 1317 WHEAT RD, 67156
 221-3200 49530610054
 39 M 49530 IM

MAC KILLOP JR MD, DANIEL, 4 FLEETWOOD DR, 67156
 2407380609
 11 M 2407 62 00

MILLER MD, FRANKLIN R, 301 PARK, 67156
 2401270739
 02 M 2401 54 00

PRICE MD, PETER G, PO BOX 651, 67156
 221-9292 64901520338
 26 M 64901 57 GS

SAMUEL MD, CHANOEY C, 1211 E FIFTH, 67156
 221-6100 49527590166
 35 M 49527 76 GS

SHIPPEY MD, DEAN U, 204 CEDAR LN DR, 67156
 221-7129 64914800119
 49 M 64914 85 R

STURICH MD, JORGE M, 1211 E 5TH, 67156
 221-6100 64914771763
 54 M 64914 84 FP

WELLS MD, BRUCE W, PO BOX 643, 67156
 221-3350 1902640947
 39 M 1902 65 IM

WHITE MD, R BURNLEY, 117 W 9TH, 67156
 221-2950 1902520763
 24 M 1902 52 FP

WINBLAO MD, J KENT, 15 FLEETWOOD, 67156
 221-6100 1902761558
 51 M 1902 74 OBG

WINBLAO MD, JAMES N, 1211 E 5TH ST, 67156
 221-6100 1902530955
 27 M 1902 53 GS

WINBLAD MD, JOHN M, 1211 E FIFTH, 67156
 221-6100 1902810818
 55 M 1902 82 FP

YATES CENTER — 316
(Allen County Medical Society)

ATKIN MD, J O, 1004 E MADISON, 66783
 625-2312 3901610052
 35 M 3901 63 FP

VORHEES MD, VICTOR J, 204 S MAIN, 66783
 625-2162 1902681023
 36 M 1902 69 FP

WEBER MD, RUTH M, 204 S MAIN, 66783
 625-2162 2846840781
 60 F 1902 85 FP

Resident Physician Section

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 ATWOOD D O,ERIC B, BOX 829, TOPEKA, 66601
 BANKS MD,DONALD E, 10D4 CHEROKEE LN PO BOX 298, PAOLA, 66701
 BEILMAN MD,GREG, 665 N VOLUTSIA, WICHITA, 67214
 BENNING MD,TIMOTHY C, 1915 HOMESTEAD, WICHITA, 67208
 BERGH MD,JAMES R, 1501 NE 78, KANSAS CITY, 64118
 BRADY MD,MARK D, 513 E MARION RD #211, WICHITA, 67216
 BRAMBLE MD,JANA D, 940D NW BARRY RD, KANSAS CITY, 64153
 BRAUN MD,STEVEN O, KUMC 39TH & RAINBOW, KANSAS CITY, 66103
 BROWN MD,TODD A, 3430 EDDGMONT ST, WICHITA, 67208
 BRUNNER MD,CHRIS N, 3243 E MURDOCK STE 303, WICHITA, 67208
 BURKE MD,MICHAEL J, 159 CIRCLE DR, WICHITA, 67218
 CARNEY MD,LISA A, 12811 W 88 CIR #128, SHAWNEE MISSION, 66215
 CHHATRE MD,MADHUKAR, 39TH & RAINBOW, KANSAS CITY, 66103
 CHOWHARY MD,RAVI, 11538 GDDARD, SHAWNEE MISSION, 66210
 CHRISTENSEN MD,ERIC C, 6025 KENWOOD AVE, KANSAS CITY, 64110
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 CRISP-LINOGREN MD,NAOMA, 2910 S BELMONT, WICHITA, 67208
 DE WITT MD,BARBARA L, 8213 EATON, KANSAS CITY, 66103
 DEAN MD,DAVID P, UKSM-W SURG 929 N ST FRANCIS, WICHITA, 67214
 DEGNER MD,REX A, 3515 BROADWAY, GREAT BEND, 67530
 DEVOSS MD,MARK R, 5418 PLAZA LN, WICHITA, 67208
 DILLARO MD,SANDY R, 929 N ST FRANCIS ANES DEPT, WICHITA, 67214
 OOMME JR MD,SYLVESTER A, 925 N EMPORIA, WICHITA, 67214
 OONNELLY MD,WILLIAM P, 70DD W 121ST, SHAWNEE MISSION, 66209
 ECK MD,MARIE M, 2444 MCLEAN, WICHITA, 67204
 EDMONDS MD,MARTA J, 4620 W 72ND, SHAWNEE MISSION, 66208
 EDWARDS MD,SHELLEY J, 5413 FOXRIDGE DR #3-305, SHAWNEE MISSION, 66202
 ELCDCK MD,DAVID G, 3518 W 83RD APT 212, SHAWNEE MISSION, 66208
 ENGEN MD,PHIL L, 2028 CHESTER, KANSAS CITY, 66103
 ENSROTH MD,KENNETH A, PO BOX 829, TOPEKA, 66601
 ERDWIEN MD,BARBARA A, 3838 RAINBOW #1403, KANSAS CITY, 66103
 EWING MD,DAVID L, 39TH & RAINBOW NEURD DEPT, KANSAS CITY, 66103
 FAILING MD,TRENT L, 527 PERSIMMON DR, OLATHE, 66061
 FAST MD,GARY A, 400 W CENTRAL ST #3402, WICHITA, 67203
 FEAGINS ALEXANDER MD,SHIRLEY J, PO BOX 7816D1, WICHITA, 67278
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 FITZGERALD DO,DAVID J, 1010 N KANSAS, WICHITA, 67214
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 FRANK MD,MARY S, 3756 SW WOODVALLEY DR, TOPEKA, 66610
 GABRIELLI JR MD,WILLIAM F, 6840 W 51ST TER #3C, SHAWNEE MISSION, 66202
 GLOVER II MD,RICHARD M, 9144 ACUFF LANE, SHAWNEE MISSION, 66215
 GOINS MD,BONNIE K, 9251 NIEMAN RD, SHAWNEE MISSION, 66214
 GRAESSELE D O,DONNA M, 17216 W 67TH, SHAWNEE MISSION, 66216
 GRAHAM JR MD,ARNOLD R, 3156 WOODVIEW RIDGE DR #207, KANSAS CITY, 66103
 GREENWOOD MD,MELANIE A, 1131 S CLIFTON, WICHITA, 67218
 GRIFFITT MD,WESLEY E, 4310 FRANCIS, KANSAS CITY, 66103
 GRILLDT MD,MICHAEL B, 3511 ELMWOOD, WICHITA, 67218
 GRISSOM MD,RHONDA G, 7724 W 97TH, SHAWNEE MISSION, 66212
 GUPTA MD,GANESH G, 550 W CENTRAL A #11D7, WICHITA, 67203
 HAMPEL MD,KEVIN G, 2739 S EXCHANGE, WICHITA, 67217
 HARRINGTON MD,ELAINE M, 5737 AYESBURY CIR, WICHITA, 67220
 HASLETT MD,MARK G, PO BOX 829, TOPEKA, 66601
 HATCHER MD,ELIZABETH R, MENNINGER BOX 829, TOPEKA, 66601
 HAY MD,JAMES R, 2341 CAPRI LN, WICHITA, 67207
 HEIN MD,DANIEL J, 2130 E CRAWFORD STE 112, SALINA, 67401
 HEIT MD,JOSEPH A, 6037 WOODSON RD, SHAWNEE MISSION, 66202
 HEMAY MD,AMIR A, 4722 SOMERSET DR, SHAWNEE MISSION, 66207
 HIGGINBOTHAM MD,OENNIS G, 959 CIMARRON TRAIL, GARDNER, 66030
 HOBUS MD,PAUL A, 538 S BELMONT, WICHITA, 67218
 HOEHNE MD,TERRY G, 5214 JUNIPER, SHAWNEE MISSION, 66205
 HOPPDCK MD,KEVIN C, 252 S BATTIN, WICHITA, 67218
 HORTON MD,GREG A, 4105 ADAMS, KANSAS CITY, 66103
 HOUGHTON MD,HOWARD L, KUMC 39TH & RAINBOW, KANSAS CITY, 66103
 HUGHES MD,DOUGLAS W, 3127 S 49TH TER, KANSAS CITY, 66106
 ISAAC,STEVEN R, 1945 N ROCK RD A #14D4, WICHITA, 67206
 JENSEN JR MD,JOHN T, 7400 E 32ND ST N A #5D2, WICHITA, 67226
 JOHNSON MD,LINDA M, 89D5 MOHAWK LN, SHAWNEE MISSION, 66206
 KALIVAS MD,LINDA L, 12300 PAWNEE LN, SHAWNEE MISSION, 66209
 KARDATZKE MD,DAVID S, 2530 GREEN MEADOW CIR, WICHITA, 67205
 KAUER MD,CURTIS D, 4174 CAMBRIDGE, KANSAS CITY, 66103
 KELLY MD,MICHELE, 8318 REEDS LANE, SHAWNEE MISSION, 66207
 KENNEDY MD,MICHAEL L, 6023 W 54TH, SHAWNEE MISSION, 66202
 KHURANA MD,VIJAY K, UKSM - WICHITA 1010 N KANSAS, WICHITA, 67214
 KIMPLE MD,KRIS G, 2008 S ESTELLE, WICHITA, 67211
 KING MD,BRADLEY S, 1114 S YALE, WICHITA, 67218
 KORTJE MD,DAVID K, 1131 S CLIFTON, WICHITA, 67218
 KRATZ MD,DDNALD, 4131 E DOUGLAS, WICHITA, 67218
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 LICHTY MD,DAN M, 1721 S CYPRESS, WICHITA, 67207
 LDRTZ MD,PHILIP W, 1331 S PERSHING #V, WICHITA, 67218
 MALDNE MD,DAVID G, 5102 WALMER, SHAWNEE MISSION, 66204
 MANSUR MD,LISA I, 2521 S KANSAS, WICHITA, 67216
 MARTINSON MD,EDWARD E, KUMC - REHAB 39TH & RAINBOW, KANSAS CITY, 66103
 MAVEC MD,JAMES A, 4467 BOOTH, KANSAS CITY, 66103
 MCANELY MD,ROBERT D, KUMC 39TH & RAINBOW, KANSAS CITY, 66103
 MCKITTRICK MD,RICHARD, 5544 CHADWICK, SHAWNEE MISSION, 66205
 MEIER MD,MITCHELL S, 550 N HILLSIDE, WICHITA, 67214
 MENNINGER MD,BRENT D, 2417 SW SUNSET CT, TOPEKA, 66604
 MERRITT MD,GREGORY A, 39TH & RAINBOW BLVD, KANSAS CITY, 66103
 MEYER MD,MARK C, 6549 W 49TH, SHAWNEE MISSION, 66202
 MILLS MD,CRAIG G, 2DD7 FEDERAL, KANSAS CITY, 66103
 MODELL MD,ELLEN M, 5210 W 69TH, SHAWNEE MISSION, 66208
 MORGAN MD,MITCH A, 947 EMERSON ST, WICHITA, 67212
 MULLINS MD,JOHN R, 219 S FOUNTAIN ST, WICHITA, 67218
 MURPHY MD,WILLIAM R, 7945 FALMOUTH, SHAWNEE MISSION, 66208
 NASH MD,CYNTHIA I, 1131 S CLIFTON, WICHITA, 67218
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 NEUBAUER MD,MARCUS A, 3001 W 47TH TER, SHAWNEE MISSION, 66205
 NICHOLS MD,JON C, 5107 OUTLOOK, SHAWNEE MISSION, 66202
 NOLLA MD,LORRAINE B, 643 N LORRAINE ST, WICHITA, 67214
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 PAULS MD,DAVID G, 2728 W 17TH, WICHITA, 67203
 PENNINGTON MD,PHILIP A, 39TH & RAINBOW, KANSAS CITY, 66103
 PETERS MD,TIMOTHY R, 36DD E HARRY, WICHITA, 67218
 PETERSON MD,STEPHEN E, MENNINGER PO BOX 829, TOPEKA, 66601
 PINKHAM MD,CHRIS M, 1018 BROADWAY #504, KANSAS CITY, 64105
 PLUMB MD,RENNE L, 4400 ADAMS, KANSAS CITY, 66103
 PDRREBARAC MD,FRANCIS A, 1010 N KANSAS, WICHITA, 67214
 PORTER MD,SCOTT W, 2029 N WOODLAWN ST #920, WICHITA, 67208
 POULOSE MD,ANIL K, 1216 SANTA FE, LEAVENWORTH, 66048
 RASMUSSEN MD,T J, 38D1 W 61ST TER, SHAWNEE MISSION, 66205
 REGISTER JR MD,G ASHLEY, 1131 S CLIFTON, WICHITA, 67218
 REICHENBERGER MD,RONALD J, 5D1 S SUMMIT LAWN, WICHITA, 67209
 REISWIG MD,GARY W, 2023 N WOOD CT, WICHITA, 67212
 RENNER MD,PATRICK A, 5709 BIRCH, SHAWNEE MISSION, 66205
 RUPP MD,JAMES C, 5030 GLENWOOD ST #7, SHAWNEE MISSION, 66202
 RYAN JR MD,RAYMOND J, 929 N ST FRANCIS, WICHITA, 67214
 SANONESS MD,KATHLEEN M, 2520 W 46TH, KANSAS CITY, 66103
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 SCHDWENGERDT MD,ANOREW W, PO BOX 384, MONTEZUMA, 67867
 SCHDWENGEROT MD,ANIEL B, 1131 S CLIFTON, WICHITA, 67218
 SCHROFF MD,GREGORY P, 3715 CAMBRIDGE, KANSAS CITY, 66103
 SCHWERTFEGER MD,TY L, 448 N FOUNTAIN, WICHITA, 67208
 SHELL MD,JOHN R, 814 W 75TH ST, KANSAS CITY, 64114
 SHERARD MD,SARAH L, 1509 W 20TH PARK PL, EMPORIA, 66801
 SIMONY-SCOLOFSKY MD,M ANN, 5020 SOUTHRIDGE, SHAWNEE MISSION, 66205
 SIMS MD,PETER MORRIS, 2524 SW BRANOWYNE LN #2, TOPEKA, 66614
 SPRADLIN MD,MICHAEL L, RR 1 BOX 185, CHERRYVALE, 67335
 STASS-ISERN MD,MERRILL, 4601 DRVILLE STE 12, KANSAS CITY, 66102
 STEINES MD,MICHAEL W, 39TH & RAINBOW, KANSAS CITY, 66103
 STEWART MD,DANIEL L, 550 N HILLSIDE, WICHITA, 67214
 STOCKTON D O,MICHAEL A, 5800 SW 6TH, TOPEKA, 66601
 STURGEON MD,JOHN B, 7800 MOHAWK, SHAWNEE MISSION, 66208
 SWARTZ MD,MARSHA A, 9341 E SKINNER ST, WICHITA, 67207
 TALBERT MD,TIMOTHY C, 3421 PENLEY DR, WICHITA, 67218
 THOMAS MD,STANLEY M, 62D2 ROBINSON #4, SHAWNEE MISSION, 66202
 THORNTON III MD,FOXHALL P, 12305 S DARNELL, OLATHE, 66062
 TIPTON MD,KYLE M, 351 N WOODLAWN ST, WICHITA, 67208
 TRYGG MD,KELLY A, 101D N KANSAS, WICHITA, 67214
 VAN DE VEER MD,SCOTT M, 4104 ADAMS, KANSAS CITY, 66103
 VANDIVORT MD,ANIEL L, 4127 BOOTH, KANSAS CITY, 66103
 VANVELDHUIZEN MD,PETER J, 6885 W 51ST TERR #1D, SHAWNEE MISSION, 66202
 VDRAN MD,DAVID A, 8629 RILEY, SHAWNEE MISSION, 66212
 WALLACE D D,RICHARD B, 1010 N KANSAS, WICHITA, 67214
 WAXMAN MD,STEVE, 2604 W 45TH AVE, KANSAS CITY, 66103
 WEINER MD,GARY B, 10738 GLENWOOD #E, SHAWNEE MISSION, 66211
 WIENS MD,JOHNATHAN G, 7746 BIRCH, SHAWNEE MISSION, 66208
 WIENS MD,LYNN A, 8814 WAYNE, KANSAS CITY, 64131
 WILSON MD,J WELLS, 550 N HILLSIDE, WICHITA, 67214
 WILSON MD,LORI J, 5441 FOXRIDGE DR #201, SHAWNEE MISSION, 66202

Medical Student Section

AHUJA, KIRAN S, 12310 OVERBROOK CT, SHAWNEE MISSION, 66209
 ALLEN, JAY L, 6905 50TH PL #207, SHAWNEE MISSION, 66202
 ALLMAN RYAN, LORI, 11932 GRANOVIE ST, SHAWNEE MISSION, 66213
 ALVARADO, LORRAINE, 3550 RAINBOW BLVD #126, KANSAS CITY, 66103
 AMIRANI, HOSSEIN, 8406 E HARRY ST #716, WICHITA, 67207
 ANDERSON, DEBORAH A, 2520 W 39TH AVE, KANSAS CITY, 66103
 ANDERSON, SUSAN R, 5100 FOXRIDGE DR #612, SHAWNEE MISSION, 66202
 ARGO, TANYA, 4209 W 48TH, SHAWNEE MISSION, 66205
 AUSTIN, CRAIG T, 5031 CANTERBURY, SHAWNEE MISSION, 66205
 BABEL, DOUGLAS B, 2118 BRISTOW AVE, KANSAS CITY, 66103
 BAKER, TRACY M, 1932 S ERIE ST, WICHITA, 67211
 BALLESTER, JOHN M, 3726 CAMBRIDGE ST, KANSAS CITY, 66103
 BANTRUP, GREGORY W, 6 W 96TH ST, KANSAS CITY, 66114
 BANWART, JON C, 5023 60TH TER, SHAWNEE MISSION, 66205
 BARBIERI, CRAIG D, 3158 WOOD VIEW RIDGE DR #304, KANSAS CITY, 66103
 BARTH, BRAULEY E, 4107 BELL, KANSAS CITY, 66111
 BEGGS, DANIEL A, 5322 SYCAMORE OR, SHAWNEE MISSION, 66205
 BENJAMIN, ASHLEY B, 2612 STRATFORD RD, LAWRENCE, 66049
 BEY, LOVIE O, 6800 E 99TH TERR, KANSAS CITY, 66134
 BHAGAT, KUNAC P, 3550 RAINBOW BLVD #105, KANSAS CITY, 66103
 BIGHAM, BRYON S, RR 1 BOX 246, ELLSWORTH, 67439
 BILLINGS, BRIAN M, 4141 EATON, KANSAS CITY, 66103
 BITTER, CINOY C, 5030 GLENWOOD ST A #1, SHAWNEE MISSION, 66202
 BLACK, KATHLEEN M, 4155 EATON, KANSAS CITY, 66103
 BLEVINS, ALETA E, 201 S HIGHWAY 69, FRONTENAC, 66762
 BOOTH, JENNIFER L, 5600 W 50TH ST, SHAWNEE MISSION, 66202
 BORROR, CHERYL, 400 W CENTRAL STE 2910, WICHITA, 67203
 BOUD, THOMAS J, 15925 BECKETT LANE, OLATHE, 66062
 BOYCE, MARY C, 6747 PAR LANE APT 1206, WICHITA, 67212
 BRACK, JULIE O, 5249 ALOER OR, SHAWNEE MISSION, 66205
 BRADFORD, DONNELL L, 1100 COUNTY LINE RD BLOG 11, KANSAS CITY, 66103
 BRADLEY, KENT R, 1709 PARK PL #2, WICHITA, 67203
 BRECHISEN, NANCY L, 4419 EATON, KANSAS CITY, 66103
 BREWER, SUSAN J, 1242 N OELLROSE ST, WICHITA, 67208
 BRILLHART, KATHERINE O, 6339 REEDS OR, SHAWNEE MISSION, 66202
 BRITTAN, ANDREW M, 4417 W 70TH TERR, SHAWNEE MISSION, 66208
 BROOKS, PAUL, 3824 BOOTH #10, KANSAS CITY, 66103
 BURCH, CINOY M, 4310 W 82ND TERR, SHAWNEE MISSION, 66208
 BUSHELL, KRISTEN, 4205 BOOTH, KANSAS CITY, 66103
 CABRERA, ANTHONY, 4008 ADAMS, KANSAS CITY, 66103
 CAMERON, JEFF W, 4733 BELINOER CT, SHAWNEE MISSION, 66205
 CAMPBELL, ELIZABETH A, 7917 ROSEWOOD, SHAWNEE MISSION, 66208
 CAO, THAI H, 39TH & RAINBOW BLVD STU BOX 31, KANSAS CITY, 66103
 CARPIND, STEPHANIE J, 5926 WOODSON RD #301, SHAWNEE MISSION, 66202
 CARVER, DEBORAH L, 5319 W 23 TER, TOPEKA CITY, 66614
 CARVER, RONALD C, 7820 MARTY ST #520, SHAWNEE MISSION, 66204
 CASIOY, SHANNON L, 10867 RICHARDS CT, SHAWNEE MISSION, 66210
 CASTRISOS, JAMES C, 9702 W 18TH ST CT N, WICHITA, 67212
 CHANG, CRAIG G, 3805 BOOTH ST, KANSAS CITY, 66103
 CHANG, MORRIS, 14501 WILLOWBEND CIR, WICHITA, 67230
 CHEN, EDWARD C, 2424 W 40TH #2, KANSAS CITY, 66103
 CHO, STEVE Y, 2323 N WOODLAWN #207, WICHITA, 67220
 CHRISTIAN, MARY K, 437 S CRESTWAY, WICHITA, 67218
 CLOUGH, JOHN A, 4147 CAMBRIDGE ST, KANSAS CITY, 66103
 COATES, SCOTT O, RR 4 BOX 8, CHANUTE, 66720
 COCHRAN, KIMBERLY A, 1257 E WESTERFIELD PL, OLATHE, 66061
 COHLMIA, SAM N, 1202 PATRICIA, WICHITA, 67208
 CONE, PATRICIA A, 1920 NEBRASKA AVE, KANSAS CITY, 66102
 CONNELL, CHRISTINA Y, 3028 E ENGLISH ST, WICHITA, 67211
 COSTA, JOHN A, 10404 W 70TH TERR #204, SHAWNEE MISSION, 66203
 COX, REAGAN M, 3580 RAINBOW BLVD #811, KANSAS CITY, 66103
 COX, STEVEN W, 3520 RAINBOW BLVD #727, KANSAS CITY, 66103
 COYLE, DEBORA S, 400 W CENTRAL #2917, WICHITA, 67203
 CRADDOCK, TERRY M, 39TH & RAINBOW MEO BOX 259, KANSAS CITY, 66103
 CURTIS, STEPHEN L, 1715 S 31ST APT A, KANSAS CITY, 66106
 DANIELS, PETRAKIS, PATRICIA M, 3006 EATON, KANSAS CITY, 66103
 DATTIEL, FREDERICK, 5028 E 120TH TERR, SHAWNEE MISSION, 66209
 DAVIES, JONATHAN W R, 3838 RAINBOW BLVD #1503, KANSAS CITY, 66103
 DE LA PEORAJA, JORGE L, 3550 RAINBOW #212, KANSAS CITY, 66103
 DEFREES, DANIEL J, 9100 E HARRY ST A #613, WICHITA, 67207
 DEVIN, ROBERT P, 6834 LOCUST, KANSAS CITY, 66131
 DIANO, MARCEL L, 3952 ADAMS #14, KANSAS CITY, 66103
 DICKEY, SUSAN O, 3744 CAMBRIDGE, KANSAS CITY, 66103
 DICKINSON, JAMES M, 1305 W 40TH, KANSAS CITY, 66111
 DUGGINS, MAURICE L, 9400 E LINCOLN ST A #811, WICHITA, 66207
 DURHAM, JANE, 4320 W 64TH, SHAWNEE MISSION, 66208
 EYE, DIANNA P, 3040 FRANCIS ST #101, KANSAS CITY, 66103
 ECKERT, CYNTHIA S, 3744 CAMBRIDGE ST, KANSAS CITY, 66103
 EDELL, THOMAS A, 1100 COUNTY LINE RD 7-9, KANSAS CITY, 66103
 EDSSELL, THOMAS, 1100 COUNTY LINE RD #9, KANSAS CITY, 66103
 EL-GHAZZAWY, ADEL G, 3580 RAINBOW BLVD APT 821, KANSAS CITY, 66103
 EMOCH III, OUARO W, 7813 W 117TH TER, SHAWNEE MISSION, 66210
 EVANS, GENE H, 8406 E HARRY ST A #305, WICHITA, 67207
 FALTER, RICHARD T, 3580 RAINBOW BLVD #827, KANSAS CITY, 66103
 FAULK, L CHRISTINE, 4117 ADAMS ST #301, KANSAS CITY, 66103
 FERGUSON, DIANE M, 3540 RAINBOW BLVD #325, KANSAS CITY, 66103
 FERGUSON, CHARLES E, 3170 WOOD VIEW RIDGE OR #306, KANSAS CITY, 66103
 FIFE, EDGAR A, 1100 COUNTY LINE #4-34, KANSAS CITY, 66103
 FISCHER, KENNY A, 4107 FRANCIS, KANSAS CITY, 66103
 FISHER, KAY, 1776 S 32ND, KANSAS CITY, 66106
 FITZSIMMONS, CURTIS J, 3811 SPRINGFIELD #28, KANSAS CITY, 66103
 FLEMING, DONNA J, 3824 BOOTH ST APT 8, KANSAS CITY, 66103
 FRANK, KENNETH J, 8811 GALLERY ST, SHAWNEE MISSION, 66215
 FREDRICKSON, DAVID P, 1721 SW 37TH, TOPEKA, 66611
 FREDRICKSON, ERIC R, 2407 W 45TH AVE, KANSAS CITY, 66103
 FRISKEL, ERIC O, 3570 RAINBOW BLVD APT #613, KANSAS CITY, 66103
 FRITZ, DAVID, 1816 CYPRESS LN, NEWTON, 67114
 GARNER, STEVEN A, 3932 ADAMS APT 23, KANSAS CITY, 66103
 GARNER, WILLIAM J, 6454 W 89TH ST #82, SHAWNEE MISSION, 66212
 GEMPERLI, AMY WISE, 2610 W 10S, SHAWNEE MISSION, 66206
 GILLOGLY, MARILYN B, 5300 W 57TH TER, SHAWNEE MISSION, 66205
 GLEASON, DOUGLASS S, 3806 STATE LINE, KANSAS CITY, 66103
 GOLDBERG, MARCEL A, 1108 SUNTREE PL #19D7, KANSAS CITY, 66102
 GOLSTEIN, JOYCE, 13202 BARKLEY, SHAWNEE MISSION, 66209
 GRACE, CAROL, 6218 ROBINSON #4, SHAWNEE MISSION, 66202
 GRAHAM, JOHN O, 1945 N ROCK RD #1112, WICHITA, 67206
 GRANTHAM, J AARON, 6615 W 69, SHAWNEE MISSION, 66204
 GRATNY, LINDA L, RR 3 BOX 513, LEAVENWORTH, 66048
 GRAY, APRIL K, 3634 WYOMING 2C, KANSAS CITY, 66111
 GREEN, BART P, 1157 S WEBB RD A #1010, WICHITA, 67207
 GREEN, JUSTIN L, 2934 FRANCIS ST #301, KANSAS CITY, 66103
 GREEN, KEITH W, 959 S BLECKLEY #105, WICHITA, 67218
 GREENFIELD, MICHAEL A, 8115 W 97TH ST, SHAWNEE MISSION, 66212
 GROSSER, DAVID M, 5100 FOXRIDGE DR A #712, SHAWNEE MISSION, 66202
 GROTH, STEPHAN J, 9935 W 60TH TER, SHAWNEE MISSION, 66203
 GUILLAUME, CAROLE A, 1919 OLATHE BLVD #305, KANSAS CITY, 66103
 GUPTA, ARCHANA, 1616 UNIVERSITY APT A, WICHITA, 67213
 HALVORSON, BEESLEY, KARI J, 101 N JANELL, OLATHE, 66061-1750
 HAMILTON, DEBORAH K, 1770 S ROCK RD #912, WICHITA, 67207
 HANNA, DEBRA S, 3550 RAINBOW BLVD APT 116, KANSAS CITY, 66103
 HARDEN, DAVID W, 345 RAINBOW LAKE RD, WICHITA, 67235
 HARRIS, BRYAN O, 3838 RAINBOW BLVD #1405, KANSAS CITY, 66103
 HARRISON, PAMELA O, 1945 N ROCK RD A #2221, WICHITA, 67206
 HARTEL, KELLY LIZABETH, 2920 W 84TH TERRACE, KANSAS CITY, 66109
 HARTIG JR, DONALD E, 4808 EASTWOOD APT A, WICHITA, 67218
 HATFIELD, ALLYSON A, 400 W CENTRAL ST A #1103, WICHITA, 67203
 HATTAMER, STEVEN, 7809 W 60 TERR, SHAWNEE MISSION, 66202
 HEAO, OIANE E, 3744 CAMBRIDGE, KANSAS CITY, 66103
 HEEB, JON J, 3804 BOOTH #8, KANSAS CITY, 66103
 HENRY, JEFFREY, 7515 COOY ST #4, SHAWNEE MISSION, 66214
 HENSEL JR, JOHN M, 14617 W 91ST TERR, SHAWNEE MISSION, 66215
 HERNADEZ, LISA M, 305 E 66TH TER, KANSAS CITY, 66113
 HIGHTNIGHT, JAMES E, 2213 W 79TH TERR, SHAWNEE MISSION, 66208
 HILGER, MARK A, 3811 SPRINGFIELD #1A, KANSAS CITY, 66103
 HILLYER, JON F, MEO STU BOX 310 39TH & RAINBOW, KANSAS CITY, 66103
 HILTON, KEVIN R, 4809 WOOD OR, SHAWNEE MISSION, 66203
 HINSHAW, DARLA J, 2613 ESSEX, KANSAS CITY, 66103
 HINTON, DONALD, 3580 RAINBOW BLVD #812, KANSAS CITY, 66103
 HOPKINS, KATHY S, 5618 MARTY, SHAWNEE MISSION, 66202
 HOVORKA, JOHN, 4745 FALMOUTH, SHAWNEE MISSION, 66205
 HUEBERT, KORY, 2809 S EMPORIA ST A #1506, WICHITA, 67216
 HUSER, PAUL W, 6001 E ROCKWOOD, WICHITA, 67208
 HWANG-HAMILTON, SHAN-SHAN, 4217 ADAMS, KANSAS CITY, 66103
 JACKSON, MICHAEL R, 2625 S WEST ST #719, WICHITA, 67217
 JACKSON, ROBERT, 4450 FRANCIS ST #1, KANSAS CITY, 66103
 JACOB, SERA L, 7809 FONTANA, SHAWNEE MISSION, 66208
 JACOBS, TOMAYO S, 5708 WEBSTER, KANSAS CITY, 66104
 JACOBSON, ERIC, 2518 N PARKWOOD CT, WICHITA, 67220
 JATA, MARY A, 7117 SUMMIT ST, KANSAS CITY, 66114
 JOACHIMS, BRIAN V, 7128 NEWTON OR, SHAWNEE MISSION, 66204
 JOHANNING, JASON M, 3540 RAINBOW BLVD #824, KANSAS CITY, 66103
 JOHNSON, BRIAN A, 637 S ERIE ST, WICHITA, 67211
 JONES, OAVIO K, 400 W ELM APT 36, OLATHE, 66061
 JONES, KELLY L, 3205 W 84TH PL, SHAWNEE MISSION, 66206
 JONG, CAROL N, 1100 COUNTY LINE RD #7-4, KANSAS CITY, 66103
 JUDD, KATHLEEN M, 8417 REINHARDT ST, SHAWNEE MISSION, 66206
 KASPER, MICHAEL L, 2701 EATON ST, KANSAS CITY, 66103
 KASSELMAN, JEFFREY P, 10806 W 75TH TERR, SHAWNEE MISSION, 66214
 KAUFFMAN, KURT A, 3726 CAMBRIDGE ST, KANSAS CITY, 66103
 KAUFMAN, LEONARD, 3838 RAINBOW BLVD #304, KANSAS CITY, 66103
 KEEVER, CRAIG E, 1212 SW BOSWELL AVE, TOPEKA, 66604
 KELLER, JOHN W, PO BOX 953, WAKEENEY, 67672
 KHOURY, DANIEL J, 7677 E 21ST #1108, WICHITA, 67206-1021
 KIM, CLEMENT, 3812 BOOTH APT #1, KANSAS CITY, 66103
 KINGREY, DAVID A, 3028 FRANCIS APT 102, KANSAS CITY, 66103
 KIRVEN, SHARON O, 1919 OLATHE BLVD A #107, KANSAS CITY, 66103
 KITCHENS, TAMMY L, 4145 WYOMING, KANSAS CITY, 66111
 KLOSTER, DANIEL R, 1305 W 40TH ST, KANSAS CITY, 66111
 KNEIB, TIMOTHY G, 2525 W 38 #1-A, KANSAS CITY, 66103
 KNOX, DOUGLAS B, 8728 W 66TH TER, SHAWNEE MISSION, 66202
 KNUSTSON, JOHN O, 1908 BARBER, KANSAS CITY, 66103
 KOELLIKER, LESLIE M, 3821 SPRINGFIELD #2C, KANSAS CITY, 66103
 KOHLER, ULRIKE B, 4207 W 54TH TERR, SHAWNEE MISSION, 66205
 KORBER, OAVIO E, 8752 W 79TH CIR, SHAWNEE MISSION, 66204
 KUETHER, TODD A, 3703 EATON, KANSAS CITY, 66103
 LAI, JOHN O, 400 W CENTRAL ST #607, WICHITA, 67203
 LAMBERT, JACQI I, 5618 MARTY ST, SHAWNEE MISSION, 66202
 LANOAUER, KYLE H, 3838 RAINBOW #1408, KANSAS CITY, 66103
 LARREA, PABLO J, 3838 RAINBOW BLVD APT 1210, KANSAS CITY, 66103
 LARSON, MELISSA L, 8879 JUNIPER LN, SHAWNEE MISSION, 66207
 LAWS, NANCY J, 400 W CENTRAL ST #3609, WICHITA, 67203
 LEESON, MICHAEL C, 7810 RILEY ST #1027, SHAWNEE MISSION, 66204
 LEHNERT, DARREN L, 5025 GLENWOOD #1, SHAWNEE MISSION, 66202
 LEHR, CARLIE WOODS, 5313 W 70TH ST, SHAWNEE MISSION, 66208
 LEWIS, ANNA L, KU MEO CNTR MEO STU BOX 35293, KANSAS CITY, 66103
 LEWIS, E CHRISTOPHER, 3530 RAINBOW BLVD #525, KANSAS CITY, 66103
 LIU, PENNY, 2009 HILLVIEW RD, LAWRENCE, 66046
 LOGAN, DONNA L, 3226 COUNTRY CLUB, WICHITA, 67208
 LOPEZ, GRISEL, 4120 THOMPSON #17, KANSAS CITY, 66103
 LOPEZ, MARK O, 3900 BOOTH APT 9, KANSAS CITY, 66103
 LOPEZ, RUBEN J, 3900 BOOTH APT 9, KANSAS CITY, 66103
 LORENZETTI, LISA A, 4603 BROOKMOOR ST A #32, SHAWNEE MISSION, 66202
 LOWEN, DAWN E, 3550 RAINBOW BLVD #225, KANSAS CITY, 66103
 LUER, JACOB K, 2341 S BELMONT, WICHITA, 67218
 LUJAN, CHARLES R, 4132 BOOTH ST, KANSAS CITY, 66103
 LUNDAK, BRUCE E, 3176 WOODVIEW RIDGE OR #308, KANSAS CITY, 66103
 LYNCH, GREGORY P, 1305 W 40TH, KANSAS CITY, 66111
 MACE, RHONDA D, 3838 RAINBOW BLVD APT 703, KANSAS CITY, 66103
 MARKESE, SABRINA, 3808 BOOTH #11, KANSAS CITY, 66103
 MARQUETTE, RAY J, 39TH & RAINBOW MEO BOX 775, KANSAS CITY, 66103
 MARSO, STEVE P, 717 W 44TH TER, KANSAS CITY, 66111
 MASSIER, KIM M, 8501 REORUO LN, SHAWNEE MISSION, 66220

MATTHEW,BRIAN, 701 LINDBERG OR, KANSAS CITY, 64118
MAY,LANCE A, 2134 BRISTOW, KANSAS CITY, 66103
MAYS,KEVIN P, BB20 WESTLAWN ST #103, WICHITA, 67212
MCATEE,JAMES R, 9935 W 60TH TER, SHAWNEE MISSION, 66203
MCCAULEY,ROBERT L, 1891 S 32 #A, KANSAS CITY, 66106
MCOOWELL,CHARLES S, 5206 BONO, SHAWNEE MISSION, 66203
MCOOWELL,KATHLEEN L, 3815 SPRINGFIELD #20, KANSAS CITY, 66103
MEEKS, MARK A, 310 E MARY, GAROEN CITY, 67B41
MEIER,MICHAEL M, 2000 CHESTER, KANSAS CITY, 66103
MEYER,ANGELA M, B07 MARCILANE, WICHITA, 67218
MILES,WILLIAM S, 6325 W 73RD TERR, SHAWNEE MISSION, 66204
MILLER,KYLE A, \$44S FOXRIDGE OR #20B, SHAWNEE MISSION, 66202
MIMIAGA,ANNE T, 400 W CENTRAL #210S, WICHITA, 67203
MORALES JR,OSCAR, 2737 S 72ND, KANSAS CITY, 66106
MOREANO,PHILLIP A., 3580 RAINBOW #B27, KANSAS CITY, 66103
MORRIS,JENNIFER A, 3580 RAINBOW BLVD, KANSAS CITY, 66103
MOSELEY, A CANDACE, 11700 E 62ND ST, KANSAS CITY, 64133
MOSSINGHOFF,OEBOHRAH GRIESER, 3200 W 129TH, SHAWNEE MISSION, 66209
MULLENBURG,JEFFREY, 9400 E LINCOLN ST A #811, WICHITA, 67207
MULLIGAN,LINDA L, 9021 WEOD, SHAWNEE MISSION, 66212
MURPHY,TRACY O, 3726 CAMBRIDGE ST, KANSAS CITY, 66103
NASSER,KEVIN K, 3838 RAINBOW BLVO #1101, KANSAS CITY, 66103
NELSON,JANET M, 7414 CHAOWICK, SHAWNEE MISSION, 66208
NELSON,TAMMIE L, 16116 W 154TH, OLATHE, 66062
NEUHAUS,JOHN P, SOS N ROCK RD #412, WICHITA, 67206
NEWBY,CORY, 3808 BOOTH #12, KANSAS CITY, 66103
NEWELL,LINDA C, 8420 WEOD APT C, SHAWNEE MISSION, 66212
NGUYEN,Z CHAT. 2601 WEDGEWOOD. WICHITA. 67204
NIXON JR,NEO R, 2514 W 51ST, SHAWNEE MISSION, 66205
NOLA,BOUNSAVATH, 4020 WHITNEY LN, WICHITA, 67210
ORTH,GREGORY, 912 N SHERIDAN, WICHITA, 67203
PARK,RACHAEL E, 3580 RAINBOW BLVO #B07, KANSAS CITY, 66103
PARMAN,LINDA M, S009 CONSER #200, SHAWNEE MISSION, 66202
PARRISH JR,DAVIO L, 10214 W 80TH #326, SHAWNEE MISSION, 66204
PARRISH,LISA K, 437 S FLOYD ST, WICHITA, 67209
PARSA,MICHAEL B, 3838 RAINBOW BLVD #1104, KANSAS CITY, 66103
PATRON,ROBERT R, 3144 WOODVIEW RIDGE OR #202, KANSAS CITY, 66103
PETERSEN,MARK I, 120 N NETTLETON, BONNER SPRING, 66012
PETTAVEL,PAUL P, 9570-B W 86TH ST, SHAWNEE MISSION, 66212
PFEIFFER II,F MICHAEL, 2217 W 39TH #1, KANSAS CITY, 66103
PFEIFFER,BRIAN O, 3600 RAINBOW APT 312, KANSAS CITY, 66103
PITTS,JEANETTE M, 3828 BOOTH #5, KANSAS CITY, 66103
PRESCOTT,JAMES T, 7450 E 32ND ST N #605, WICHITA, 67226
PURKIS,MICHAEL O, 4117 ADAMS ST #103, KANSAS CITY, 66103
PUTNAM,ANTHONY M, 3028 FRANCIS #102, KANSAS CITY, 66103
RAD,SIMA, PO BOX 3545, KANSAS CITY, 66103
RAINS,JEFFREY, 2917 W 44TH AVE, KANSAS CITY, 66103
RAMSEY,TRACY C, B612 GRANT AVE, SHAWNEE MISSION, 66212
RANODLPH,MARY K, 10623 COUNTRYSIDE, WICHITA, 67207
RATZLAFF,JAMES O, 7620 W 63RD #209, SHAWNEE MISSION, 66202
REGAS,STEPHEN L, 3934 BOOTH #2, KANSAS CITY, 66103
REGHR,RANDALL S, 6970 WEATHERWOOD DR #107, SHAWNEE MISSION, 66217
REILE,DANA, 8810 W 64TH PL A #202, SHAWNEE MISSION, 66202
RETTELE,GARRICK A, 3735 BOOTH APT #4, KANSAS CITY, 66103
RHODE,MICHAEL G, 2626 W 9TH ST N A #211, WICHITA, 67203
RICHARDOS,DAVIO A, 8311 MASTIN ST, SHAWNEE MISSION, 66212
RICHARDSON,KAREN M, 16327 LOCUST, OLATHE, 66062
RISENHODYER,EDDIE D, 5300 ROE AVE, SHAWNEE MISSION, 66205
ROMEREIM,MARK E, 124 AARON, WICHITA, 67002
ROMERO JR,FRANK, 1100 SUNTREE PLZ #1809, KANSAS CITY, 66103
ROSADO,ANTONIO, 4372 MISSION RD, KANSAS CITY, 66103
RUCKER,MARK R, 9419 LONGLAKE ST, WICHITA, 67207
SCHMIDT,DARYN R, 39S2 ADAMS #19, KANSAS CITY, 66103
SCHNEIDER,DAVIO J, 4904 BROADMOOR #162, SHAWNEE MISSION, 66202
SCHNIEROW,BRADLEY J, 3920 BOOTH ST, KANSAS CITY, 66103
SCHROEDER,SANORA K, 425 N BROADWAY #5, WICHITA, 67202
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Survival of Patients with Cervical Carcinoma Physician to Rancher (and Back Again)



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**ABOUT OUR LOGO**

In January 1935, a new logo appeared on the cover of KANSAS MEDICINE for the first time. This device represents two stethoscopes: the original monaural type as used by Laënnec, and the modern binaural variety. The logo was designed expressly for KANSAS MEDICINE by renowned graphic designer Bradbury Thompson, a native of Topeka and friend of two former editors of the journal, Dr. W.M. Mills and Dr. Lucien Pyle. As another former editor, Dr. Orville R. Clark, wrote in January 1955, the logo "has become as much a part of the journal as any of the features on the inside and is something which is ours alone."

Francisco Vasquez de Coronado
 General Delivery
 Mexico City, Mexico

Dear Frank:

Man, time really gets away from you, doesn't it? Can it really be 450 years since you were up this way? Folks around here have been talking about your visit lately and wondering when you were going to head up this way again.

Fact is, this year there has been a little more interest in your last visit because of that 450-year thing (folks up here like to make a big deal about anniversaries), and a bunch of the guys were thinking it would be a real promotional scheme to have you visit. If you decide to come this way, there are a few pointers we can pass along. It ought to be a little easier than your first trip. You were worried (with good reason) about how the residents might receive you, and you may still find there are a few con men around to sell you on their schemes. Kansas, as we call the place now, has been known to produce a few, and that Indian you hired before was a piker compared to some — but the Boys in Blue will frown on your garrotting them if you run into any.

Anyway, when you get up to that big river (we call it the Arkansas), you will maybe feel like things are familiar. Incidentally, the folks have put up a very nice cross there which has inspired artists and photographers (copy enclosed, thanks to Jim Hamil) and Fra Juan might be glad to know there are a lot more Catholics than there were before. If you stay along the river, you'll hit Highway 56 — just stay on it until you hit Lyons, then bear left and head northeast to a place called Lindsborg. You'll find mostly Swedes there. They are known to be stubborn but generally peaceful. There's a hill close by where you were supposed to have camped — maybe you did, but if not it would be smart to say you did. You see, they put up a real nice monument to you there made by a guy named John Whitfield — used to hang around Topeka. You could go on just a little farther to a place called Bridgeport, because that is supposed to be the spot where you finally called it a bum deal and went home. Maybe you can settle that.

Well, hey, man — don't be a stranger. Give our regards to the gang, and don't wait another 450 years. You were right about the rich soil in these parts, but we could still use a little gold.

Yrs.
 D.E.G.

Suffer, the Little Children

The medical profession in this country has no greater comfort than to assure itself that it is superior to that in virtually every other country. This indicates a provinciality of thought which can be embarrassing and by no means endearing to other countries, especially when it is demonstrably wrong. Thus, it is a matter of no small dismay when information emerges (and is widely published) that the infant mortality rate in this country ranks low on the international list. The information is at once productive of a defensive attitude and indefensible. The defensive posture takes the form first of a denial and then a certainty that there are statistical flaws or inconsistencies. When the certainty of the matter becomes incontestable, there is a realization that we had better get on with an effort to correct it.



Obstetrical care has suffered from its own history, both actual and fictional. Genealogies are replete with lists of multiple wives to a husband, recording maternal mortalities poignantly if not statistically purified. Facts conflicted with the general acceptance of pregnancy as normal and warranting no great attention until the critical moment. Prenatal care was determined by social and economic circumstances we see in retrospect as regrettable — if not reprehensible. Deficiencies in medical service were cultural, socioeconomic — and professional — all incorporated into life generally. Gratifying improvements, both maternal and infant, came with infection control, blood availability, justified surgical intervention, diagnostic techniques and improved nursing care.

But now this basic physiologic function has become complicated by socioeconomic intrusions from many directions. Medicine, preoccupied with its professional services, has, until recently, failed to appreciate (or has been unable to cope with) factors it deemed outside its traditional functions. No part of medical service has been more affected by the “new” social mores than maternal and infant care. And this comes to focus nowhere more acutely than infant survival.

As seems true of many medical problems of the day, the matter becomes distractingly complicated as one goes more deeply into it. The vaunted

“freedoms” of the age led to a failure to instill on the one hand and failure to accept on the other an adequate understanding of responsibility. Families have been altered in their structure and function, a result in large part of this claim of freedom. Social mores accept illegitimate pregnancies casually (indeed, provide many role models among generally admired public figures). Adolescents, uneducated in the sexual implications of their behavior, adopt a presumption of maturity and embark on early sexual activity — in ignorance or defiance or escape.

This population of child parents is by no means the only factor. Older mothers are often unacquainted with appropriate prenatal nutrition, or unable to obtain it, or lack the sense of responsibility to seek it, or are simply “imprisoned” by an ingrained dependence upon welfare. Witness the fact that the support provisions for an additional child can provide a woman with a greater income than she could possibly command by employment. All of these factors (and more, of course) add up to an increasing number of premature babies, drug-addicted or otherwise damaged babies; babies destined (under the present circumstances) to perpetuate the problem. As the old doctor in John Irving’s *Cider House Rules* muses while looking over his nursery of squalling illegitimate infants, they were crying not to be born but because they had been born.

Ironically, medicine has contributed to the matter. Dramatic technologic advances, professional standards and social demands find measure in the highest purpose of society, which is to assure that all levels shall have the same advantages. Unfortunately, we have not learned that in this most basic of human functions, child-bearing, we owe it to our youth to pursue education early and instill not only clinical knowledge but social and personal responsibility.

Efforts to resolve these problems — financial, medical, social — do impose a bill, and we are periodically reminded that there must be finite limits to our ability to support the system. There is much talk these days about rationing of health care. It is generally related to the survival of the elderly, but perhaps they will have to be joined by the infants. Or perhaps we need to reeducate ourselves as to priorities. **D.E.G.**

Tell us where it hurts.

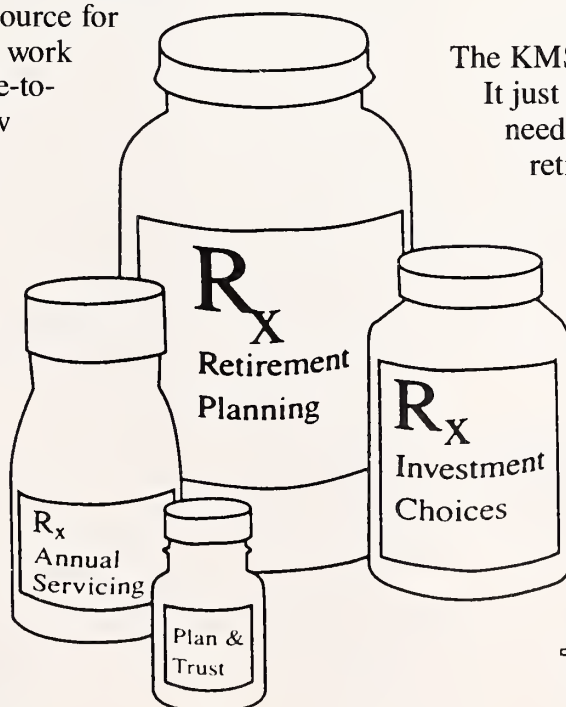
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Practice Parameters Can Be Beneficial

Practice parameters! Physician guidelines! Cookbook medicine! Who needs them? My friends, it seems that we all do. The tremendous variation in physician-ordered evaluation and treatment of identical patient problems from practice to practice and from community to community forces us to consider practice parameters which have the potential to improve the quality and decrease the cost of health care. Please consider the following examples.



It is well known that obstetrical epidural anesthesia will relieve pain, lengthen labor and delivery, increase the incidence of operative delivery and add approximately \$600 to the total charge. If that operative delivery happens to be a Cesarean section, add another \$3,000 to the cost. If epidural anesthesia is a critical component in modern obstetrics, why is this service withheld from uninsured patients in some communities if they have not prepaid for the anesthesia, and why does its utilization for vaginal delivery vary from 0% in some hospitals to 75% in others?

Although there is disagreement about the optimal screening interval, I trust that most physicians routinely use screening mammography. Part of the definition of a screening study is that the study must be "inexpensive." Most of us feel that a screening mammogram (four views and interpretation) at \$45 is reasonably priced, although maybe not inexpensive. But why is diagnostic mammography (six views and interpretation) priced at \$125? Usually the unit cost *decreases* as more units are purchased. Why are 80% of the mammograms at a hospital facility ordered as screening studies, while 80% of the studies are diagnostic at a physician-owned facility in that same community?

The American College of Obstetrics and Gynecology does not recommend routine pregnancy sonograms. Why do some physicians get two and sometimes three sonograms on each and every pregnant patient?

Back surgeons don't operate on MRIs and aren't going to operate on a patient with an "acute back" unless the pain is intractable, motor or sensory loss is present, malignancy is suspected, or major trauma was involved. Why are so many patients

with recent onset of back discomfort subjected to MRI studies without an appropriate effort at conservative management and rehabilitation? Why does Springfield, Missouri (180,000 people) have one MRI scanner while Wichita, Kansas has seven MRIs — or is it now eight?

A noted Kansas cardiologist once told me that every cardiac murmur should be evaluated by echocardiography. Will an echocardiogram change the treatment of an 82-year-old male with a grade III/IV systolic ejection murmur; normal blood pressure, pulse, heart rate and chest auscultation; and a negative review of systems?

**"Practice parameters . . .
have the potential
to improve the quality
and decrease the cost
of health care."**

We have all seen articles documenting profound variation in the incidence of hysterectomy, carotid endarterectomy, gastroscopy, etc. in comparable populations from different parts of our country. Dr. James Todd, AMA Executive Vice President, spoke in support of practice parameters at a recent AMA Leadership Conference. Dr. Todd advised physicians that freedom to practice without review is gone, and that our past autonomy of practice has in many ways contributed to our current health care dilemma.

Every six years I have gone through the recertifying exam of the American Board of Family Practice. I have found this effort, especially the review and critique of my office records, to be quite educational. Likewise, practice parameters should be educational and will be beneficial, as these guidelines will encourage some of us to:

- Expand our differential diagnosis to develop more comprehensive and aggressive diagnostic and therapeutic plans.

- Avoid studies or treatments we do not feel are necessary but order anyway because of some fear of potential medical liability, to appease the

(Continued on page 211.)

AM HIGH

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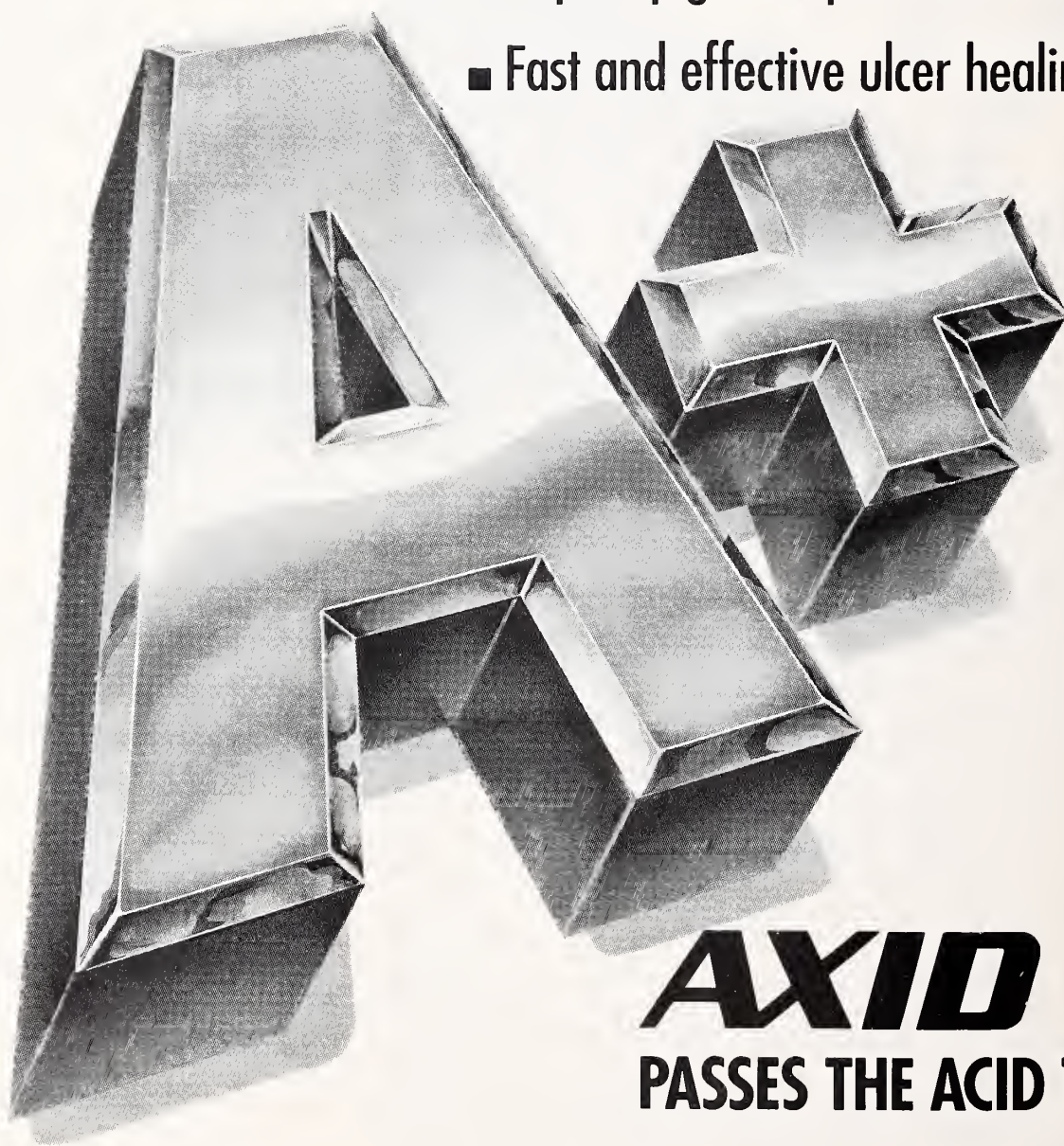


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See adjacent page for references and brief summary
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Brief Summary. Consult the package insert for complete prescribing information.
Indications and Usage: 1. *Active duodenal ulcer*—for up to 8 weeks of treatment. Most patients heal within 4 weeks.

2. *Maintenance therapy*—for healed duodenal ulcer patients at a reduced dosage of 150 mg b.i.d. The consequences of therapy with Axid for longer than 1 year are not known.

Contraindications: Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H₂-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H₂-receptor antagonists.

Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix[®] may occur during therapy.

Drug Interactions—No interactions have been observed with theophylline, chlorazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events were due to the drug.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H₂-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H₂-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis does not substantially increase clearance of nizatidine due to its large volume of distribution.

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2. *Scand J Gastroenterol*. 1987;22(suppl 136):61-70.
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demands of a persistent patient, or because we do not want to be considered inferior to the physician down the hall who always orders those studies.

● Discontinue the use of financially rewarding but clinically unnecessary diagnostic and therapeutic modalities.

Don Hatton, M.D., of Lawrence, has accepted the chairmanship of the new KMS Ad Hoc Committee on Practice Parameters. If you would like to assist in this necessary effort regarding the study and development of practice parameters, please contact Dr. Hatton, the KMS office or myself regarding your interest.

Larry Anderson MD

Council District Meeting Calendar

District 17
Tues., Oct. 1

Garden City
Southwind Country Club

District 13
Tues., Oct. 8

Hays

District 15
Tues., Oct. 15

Dodge City
Dodge City C.C.

District 8
Thurs., Oct. 17

Winfield

District 4
Thurs., Oct. 24

Parsons
Parsons C.C.

District 1
Tues., Oct. 29

Atchison
Pennell-Drury Tea Room

District 10
Mon., Nov. 4

Newton
Old Mill Restaurant

District 7
Tues., Nov. 5

Emporia
Emporia C.C.

District 12
Thurs., Nov. 7

Pratt
The Seville

District 9
Tues., Nov. 19

Salina

District 5
Wed., Nov. 20

Manhattan

Districts 2 & 3
Tues., Nov. 26

Kansas City
Indian Hills C.C.

District 11
Tues., Jan. 7

Wichita
MSSC

District 16
Spring 1992

Colby

Loss of Chance

WAYNE T. STRATTON, J.D.,* *Topeka*

In Kansas, most medical malpractice cases are based on traditional concepts of negligence and causation requiring the patient to demonstrate not only that the physician was negligent but also that the negligence caused the patient harm. Under traditional theory, causation does not exist unless the doctor's conduct is a "substantial factor" in bringing about the harm. This test requires a showing of causation by a more-likely-than-not standard made evident by a greater-than-50% probability of causation. If not, the lawsuit will be dismissed in favor of the physician before reaching the jury.



The doctrine of loss of chance, however, has defied the traditional concept of causation. The loss of a chance theory, which is probably applicable only in instances of death in Kansas, does not adhere to the greater-than-50% causation standard. Rather, the causation element will reach a jury if evidence has established that the patient had an appreciable chance to survive if given proper medical treatment.

A hypothetical case will illustrate the difference between the two: a patient has only a 30% chance of survival if he receives proper medical treatment; he receives improper medical treatment and dies. Under traditional theory there would be no malpractice case because the treatment is not a substantial factor in causing the patient's death. Using loss of a chance, the patient can recover (in the legal sense) on the theory that he was denied a chance at survival and should be compensated for the loss of that chance.

A recent Kansas Court of Appeals case dem-

*KMS Legal Counsel.

Comments appearing herein are not intended as a substitute for legal analysis or advice. Answers to legal questions depend largely upon the particular facts of a case. The reader is urged to consult an attorney for answers to specific legal questions.

These comments do not necessarily represent the views of KANSAS MEDICINE, or the Kansas Medical Society. For further information, contact Mr. Stratton, 515 S. Kansas, Topeka, KS 66603, 1-800-332-0248.

Redefining causation in medical malpractice cases.

onstrates that these survival cases do not fit neatly into either category. The case dealt with a physician's failure to exercise proper medical care in monitoring a cyst located in the patient's kidney. The cyst was later diagnosed as cancerous by a second physician, and the patient died after treatments were unsuccessful. The patient's wife and estate proceeded in a wrongful death action against the first physician, presenting both the theories of traditional negligence and loss of a chance of survival to the jury. The jury decided that the doctor's negligence was not a substantial factor in causing the patient's death, but that the patient had been denied an appreciable chance of survival. A second trial was then held and the jury did find the negligence of the physician to be a substantial factor and awarded damages based on traditional wrongful death law instead of lesser damages based on loss of a chance.

In affirming the trial court, the court of appeals said that traditional negligence rules apply when a jury finds that a patient would have had a greater-than-50% chance at survival if given proper medical treatment, not the loss of a chance rule. The court also noted that the loss of a chance rule was an exception to the normal requirement of proving causation.

The effect of this case and loss of a chance in Kansas is that if there is evidence of negligence and of an appreciable chance of survival, almost all malpractice cases involving death will be going to the jury to determine causation. The question of what is an appreciable chance of survival is vague. One case has allowed compensation for a 6% chance of survival (although evidence of a 40% chance of survival was introduced), and another court said that loss of a 5% chance was not recoverable.

Still unclear is the question of how damages will be assessed in situations involving less than a 50% loss of a chance of recovery. Presumably, this will be the subject of future judicial interpretations.

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THE WAY IT WAS

(Medical education note as reported in the June, 1903 issue of The Journal of the Kansas Medical Society.)

On May 8 and 9 there was held in Chicago a conference of university, college and medical school men relative to the correlation of the studies preparatory to a degree in medicine. The very calling of the conference shows the demand of the country for physicians who are thoroughly educated and cultured. It shows also that the physician of the future must possess at least the essentials of a college course. One of the noteworthy speeches was that of Dr. R. McE. Schauffler of Kansas City pleading for a college course preparatory to the medical school. Incidentally this speech showed the fear of the independent medical schools of going to the wall unless something is done to check the present movement toward the university training of medical students. His conclusion was that the medical schools should allow advanced standing to graduates of literary institutions only when their courses had embraced the same studies as those given in the first two years of medical school.

The American Academy of Medicine discussed the same subject at Washington on May 11 and

12. Here also there seemed to be a feeling that a medical man should have at the very least two years of the college course.

We in Kansas may congratulate ourselves therefore that the University of Kansas in providing a six years course from the high school to the degree of M.D. has registered simply the demand of the country and made it possible for the next generation of Kansas physicians to be college bred men.

(And from The Journal of the Kansas Medical Society, April 1, 1907)

KANSAS CITY AND OUR STATE UNIVERSITY

The University of Missouri has asked Kansas City for a bonus of \$150,000, and the control of the city hospital as a condition for establishing the clinical department of her medical school there. About this latter matter the Star has the following to say:

The question of City Hospital clinics has again become active through the appointment of a Council committee to carry on negotiations with the curators of the Missouri State University concerning the conditions precedent to the establishment of a state medical school in Kansas City.

The treatment of this question involves a very simple expedient, and that is a square deal for all and special privileges for none.

It has been more than intimated that the Missouri school desires to control the clinics at the public hospital. The statement that this is a misrepresentation borrows some plausibility from the fact any claim of that kind would have not the slightest groundwork, either in reason or justice. The Kansas University was the pioneer in the establishment of high grade medical work in Kansas City. That institution must not be discriminated against in the matter of clinics. It may be said it was to avail itself of these advantages that the Kansas school came to Kansas City. Nothing but equal ward privileges in the city hospital would be right or equitable.

That sentiment is plainly dominant in Kansas City, and the Missouri school would only be harmed and placed at a disadvantage by seeking to compass any advantage over the Kansas institution. — The Star, March 8, 1907

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More Thoughts On Radioactive Waste Disposal

To the Editor:

The Nuclear Medicine Section met in an informal meeting to comment on the Nuclear Regulatory Commission Policy on Low-Level Radioactive Waste.

The NRC has put forth a concept of "below Regulatory concern" for some classes of low-level radioactive waste. The below level regulatory concern policy was adopted 3 July 1990 and was intended to serve as a basis for determining when radiation levels are so low that they do not need stringent regulatory controls to ensure protection of the public and the environment. The policy has met extensive opposition from environmental and citizens groups. The Nuclear Medicine Section is on record as supporting the concept of classifying appropriate low-level waste as being "below Regulatory concern." Although Kansas is an Agreement State, and not directly under NRC regulation, NRC guidelines are followed by the Kansas Regulatory Commission.

It is our thought that Nuclear Medicine in the state of Kansas could deliver more effective patient care through the elimination and reduction of unnecessary restrictions involving some Nuclear Medicine low-level radioactive waste.

David F. Preston, M.D.

*President, KMS Nuclear Medicine Section, and
Professor of Diagnostic Radiology,
Division of Nuclear Medicine, KUMC-KC*

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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon[®] is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

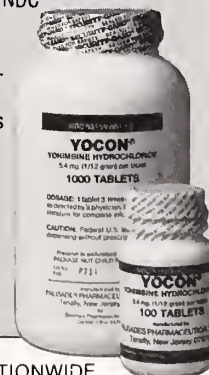
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon[®] 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
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Factors Influencing the Survival of Patients with Cervical Carcinoma

KEVIN K. NASSERI, B.S.,* BRUCE F. KIMLER, Ph.D.,†
RUTH S. HASSENEIN, Ph.D.,† AND LINDA S. GEMER, M.D.†, *Kansas City*

The management of cervical carcinoma is one of modern medicine's notable achievements. A disease which just decades ago accounted for the highest proportion of cancer deaths among U.S. women is now considered one of the more "curable" forms of cancer.¹ This tremendous decrease in deaths is the direct result of early diagnosis using the Papanicolaou smear, and of improved treatment with surgery, radiation and chemotherapy. Because of the potential for long-term survival, it is important to have an understanding of factors that influence the prognosis of patients diagnosed with cervical carcinoma. These "prognostic factors" provide basic clues regarding the underlying mechanisms of the disease process by localizing conditions that are indicative of the patient's likelihood of disease-free and absolute survival. Moreover, prognostic factors provide valuable insight for determining the proper therapy by assessing the patient's degree of risk.

In recent years, investigators have attempted to identify prognostic factors for patients with cervical carcinoma through retrospective studies of various populations.¹⁻⁵ Among the prognostic factors listed by Perez and Brady² were the presence of a bulky cervix, anemia during radiation therapy (hemoglobin less than 11 g/dl), history of hypertension (diastolic pressure above 110 mm Hg), and age at diagnosis of the cancer. More recently, Johnson et al.¹ declared clinical stage and lymphangiogram status as reliable factors, based on a study of 295 patients treated at the Stanford

University Medical Center. A similar study by Girinski et al.³ at the Institut Gustave-Roussy also established minimum hemoglobin below 10 g/dl and blood transfusions during treatment as significant risk factors. The goal of this project was to identify prognostic factors for a specific population of cervical carcinoma patients treated at the Kansas University Medical Center (KUMC).

Materials and Methods

Patient population. From the Kansas Tumor Registry, a study population of 228 patients was defined by selecting all cervical carcinoma patients with the squamous cell histology and a clinical stage of I, II or III (based on the International Federation of Gynecology and Obstetrics staging classification) who were treated at KUMC between January 1980 and December 1988. A 55-patient subset of this population was defined as those who received their complete course of radiation therapy (RT) at KUMC between January 1982 and December 1988. The starting date of 1980 was chosen for the study period based on the assumption that the patient population and the treatment strategies have been relatively constant throughout this decade. The study of the RT subset was confined to the 7-year period starting in 1982 because weekly blood count information was not routinely available prior to 1982.

Data collection. The Kansas Tumor Registry was used as the primary source of information for the 228 patients in the study population. The data extracted from the registry included the date of diagnosis of the cervical carcinoma as well as its stage, histology, grade, treatment type and outcome.

For the 55 patients in the RT subset, patient charts from the Radiation Oncology Department were reviewed for additional data concerning the neoplastic disease, the patient history and details of radiation therapy. Among these data were information regarding lymph node status, bulky cervix, hydronephrosis, menopausal status, hy-

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†Depts. of Radiation Oncology and Biometry, KUMC-KC.

Address correspondence and reprint requests to Dr. Kimler at the Dept. of Radiation Oncology, KUMC-KC, 39th & Rainbow Boulevard, Kansas City, Kansas 66103.

Gratitude is expressed to the staff of the Kansas Tumor Registry, under the direction of Frederick F. Holmes, M.D., for their assistance in making the database available for this research.

pertension and specifics of the RT (modality, total dose, treatment duration and treatment-related complications). In addition, hemoglobin and blood transfusion information were obtained from the weekly blood count values recorded during the course of the RT. The data were stored in a database using the dBASE III commercial software package (copyright 1984 by Ashton-Tate).

Statistics. Univariate analyses of the data were done by a graphical technique following transfer of the data to a second database using version 3.0 of Lotus 1-2-3 (copyright 1989 by the Lotus Development Corporation). The univariate analyses entailed dividing the population into two or more subgroups based on the factor under study and comparing the survival patterns for the subgroups. Differences in the survival rates for each set of subgroups were tested for statistical significance by the Gehan-Wilcoxon method for singly censored samples.⁶ Multivariate analyses were performed using a Cox Proportional Hazard model utilizing BMDP software (SAS Institute, Cary, NC).

Results

The results of the univariate analyses for the study population of 228 patients are presented in Table 1. Similar results for the 55 patients in the RT subset are contained in Table 2. The 5-year survival was used as the index for comparing the population subgroups, since approximately 90% of cervical carcinoma relapses occur within five years after the initial date of diagnosis.^{1, 2} The 5-year survivals for the study population and the RT subset were found to be 68% and 69%, respectively. Figure 1 shows that the survival of patients with stage I disease is significantly better

than that of the stage II and III patients ($p < 0.0001$). Similarly, patients who were below 40 years of age at the time of diagnosis had a better prognosis ($p < 0.0001$) than those 40 and older (Figure 2). Finally, grade did not appear to have a substantial effect on patient survival.

Of the prognostic factors identified in the study population, none was found to be statistically significant in the RT subset (Table 2). However, the similarity of the survival curves for the RT subset to those of the study population allows us to assume that the RT subset is a representative sample of the larger study population. The lack of significant differences is attributed only to the small sample size of 55 patients. It is probable that statistical significance for these factors would have been achieved with a larger sample size.

Turning to the analysis of factors that could be studied only in the RT subset, the sole statistically significant finding was that patients who underwent hysterectomy prior to RT had a better prognosis ($p < 0.05$). However, this is most likely due to the fact that these patients had such early disease that hysterectomy was possible, or that malignancy was an incidental finding during a procedure for a benign disorder. Although of only marginal statistical significance ($p < 0.10$), several other factors were highly suggestive for prognostic potential. Patients with lymph node metastases had a lower survival rate than those with no metastases at diagnosis. Another "apparent" prognostic factor was the minimum hemoglobin concentration during RT. As shown in Figure 3, patients whose hemoglobin measurement fell below 12.0 g/dl at any time during the course of RT had a lower survival rate. Similarly, the requirement for blood transfusion appears as a neg-

TABLE 1
UNIVARIATE ANALYSES FOR THE 228 PATIENTS IN THE STUDY POPULATION

<i>Prognostic Factor</i>	<i>No. of Patients</i>	<i>5-year Survival</i>	<i>p-value from G-W</i>
Study Population	228	68%	
Stage			
I	152	78%	$p < 0.0001$
II + III	76	47%	
Age			
< 40	88	78%	$p < 0.0001$
≥ 40	140	62%	
Grade			
1	14	47%	
2	57	67%	
3	33	57%	
Unknown	124	72%	

TABLE 2
UNIVARIATE ANALYSES FOR THE 55 PATIENTS IN THE RT POPULATION

<i>Prognostic Factor</i>	<i>No. of Patients</i>	<i>5-year Survival</i>	<i>p-value from G-W</i>
Study Population	55	69%	
Stage			
I	23	80%	p < 0.10
II + III	32	60%	
Age			
< 40	10	78%	p > 0.1
≥ 40	45	67%	
Grade			
1	2	100%	
2	26	82%	
3	12	40%	
Unknown	15	62%	
Lymph Node Metastases			
Present	12	46%	p < 0.10
None	43	78%	
Hysterectomy			
Yes	10	100%	p < 0.05
No	45	62%	
Minimum hemoglobin			
< 12.0 g/dl	30	59%	p < 0.10
≥ 12.0 g/dl	24	84%	
Blood Transfusions			
Yes	6	50%	p < 0.10
No	49	72%	

ative prognostic factor, albeit based on only 6 patients known to have received a blood transfusion during the course of RT.

Several other factors tested (tumor grade, hypertension, RT dose, duration of RT, RT complications, hydronephrosis, bulky cervix and menopausal status) were not useful in predicting survival in the RT subset ($p > 0.10$).

Discussion

Based on univariate analyses of the study population of 228 patients, stage and age at diagnosis were identified as prognostic factors. As shown by previous investigators,¹⁻⁵ clinical stage was found to be a reliable prognostic factor, with those patients having more extensive disease having a poorer prognosis. In addition, our analysis of the total population group showed that patients under 40 have a significantly higher 5-year survival rate. This is in contrast with a multivariate analysis by Dattoli et al.⁴ of 125 patients with a stage IB disease wherein patients younger than 40 had a 5-year survival of 54%, compared to 91% for those over 40 ($p = 0.0001$). However, since other authors have reported that age is not a significant prognostic factor in cervical carcinoma,¹⁻³ it is

difficult to assess the significance of age as a prognostic indicator using only univariate analyses. Therefore, we performed a multivariate analysis using the Cox Proportional Hazard model. Only stage was verified as a true, independent predictor of survival ($p = 0.001$), implying that age was simply a covariate that did not contribute additionally to the prognostic value of stage.

Similarly, univariate analyses of the RT subset (Table 2) revealed one variable that was statistically significant ($p < 0.05$) and five that were marginally significant ($p < 0.10$). Only hysterectomy was a statistically significant prognostic factor, with patients who underwent hysterectomy prior to RT having a better prognosis than those treated by RT alone. This may be because younger patients and patients with less advanced disease are better candidates for this surgery. In this case, hysterectomy would be only a covariate, rather than a true independent prognostic factor. Of note is a study by Patanaphan et al.,⁵ who reported that patients with stage IB disease treated with hysterectomy and RT actually had a lower survival than patients treated with RT alone. This discrepancy in results may be explained by the fact that Patanaphan limited his study to patients

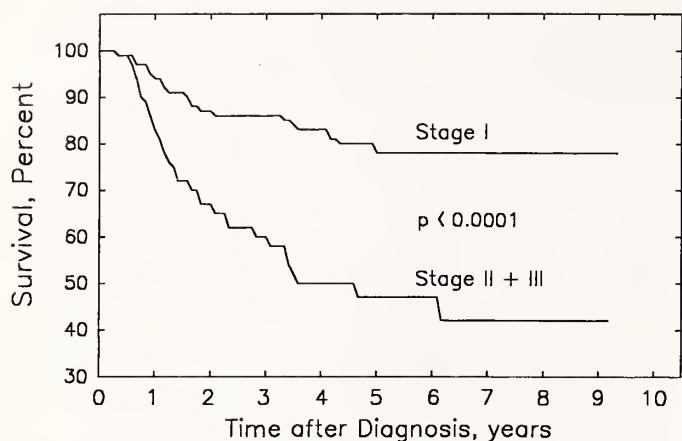


Figure 1. Effect of stage at diagnosis on the survival of 228 patients with cervical carcinoma. The two curves are statistically significantly different by univariate analysis ($p < 0.0001$) and by multivariate analysis ($p = 0.001$).

with stage IB disease, thereby eliminating patients with IA disease or disease found incidentally at the time of hysterectomy for benign causes.

The presence of lymph node metastases was identified as an apparent (but not statistically significant) prognostic factor. Specifically, presentation with positive lymph nodes reflects more aggressive disease, which carries a poorer prognosis. Minimum hemoglobin during RT and blood transfusion during RT were also identified as “apparent” prognostic factors. As shown in several studies,^{3, 7-10} minimum hemoglobin during RT was useful in predicting survival. Our results are similar to those of Bush et al.,⁷ who reported that patients with at least one hemoglobin value below 12.0 g/dl during RT had a lower survival rate than their counterparts. Since the

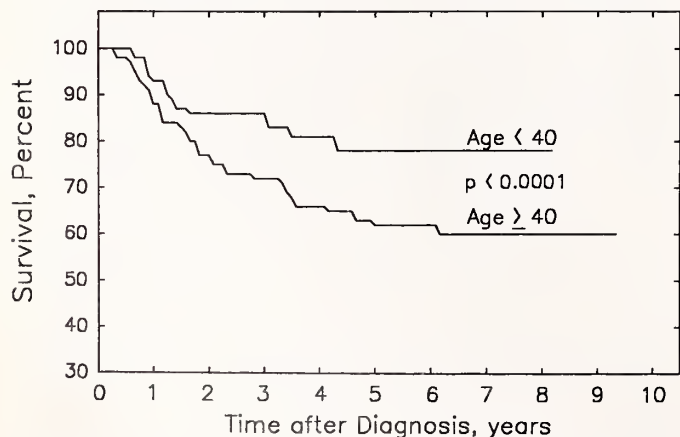


Figure 2. Effect of age at diagnosis (less than 40 versus greater than or equal to 40 years old) on the survival of 228 patients with cervical carcinoma. The two curves are statistically significantly different by univariate analysis ($p < 0.0001$) but not by multivariate analysis.

distribution of minimum hemoglobin value with respect to age and stage did not show a higher prevalence of anemia in either older patients or those with advanced stage, minimum hemoglobin during RT is probably an independent risk factor in our study. This indicates that even short periods of anemia can significantly increase the rate of local recurrence by possibly providing radioresistant pockets of hypoxia within the tumor volume.¹¹

It was difficult to perform the multivariate analysis on the RT subset because of the small sample size (10 variables and only 55 patients). Nonetheless, it did demonstrate that patients with grade 3 disease had a greater hazard (i.e., a poorer probability of survival) ($p = 0.045$). In addition, patients with positive lymph nodes had a marginally ($p = 0.06$) poorer prognosis. These are certainly consistent with common perceptions regarding carcinoma of the cervix.

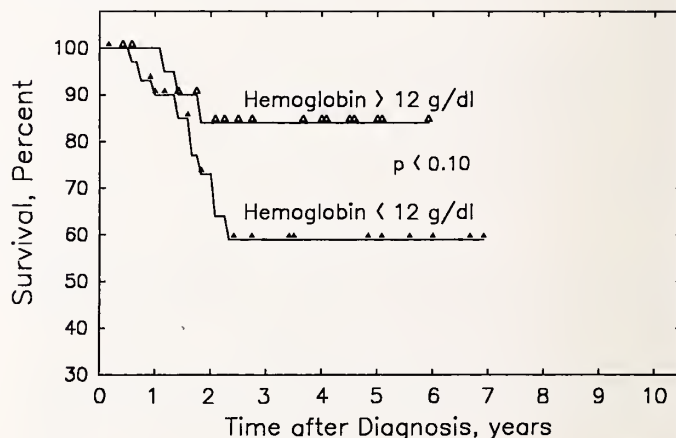


Figure 3. Effect of minimum hemoglobin concentration on the survival of 55 patients in the radiation therapy subset. Censored patients are indicated by the triangles. The two curves approach a statistically significant difference ($0.05 < p < 0.10$) by univariate analysis.

In summary, the analyses performed here indicate the importance of considering at presentation such prognostic factors as stage, grade and presence of lymph node metastases when planning treatment for the patient with stage I–III squamous cell carcinoma of the cervix. Since early stage is such a strong prognostic factor predicting a positive outcome, women should be encouraged to have screening pelvic exams and Pap smears routinely, regardless of age or sexual activity. In addition, the minimum hemoglobin during RT and the requirement for blood transfusion during RT may contribute to the prediction of outcome and survival time for this population of patients.

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Physician to Rancher (and Back Again)

PART ONE

VICTOR J. VORHEES, M.D.,* *Fredonia*

This is the first of a three-part series in which Dr. Vorhees, a family physician and rancher, relates his experiences treating his patients — both human and bovine. Not surprisingly, he finds there are similarities. . . .

During my tenure as a practicing family physician, I kept a few beef cows "on the side." Though I thoroughly enjoyed my medical practice, being a suitcase rancher rejuvenated me and allowed me to return to practice Monday with a fresh enthusiasm. This dual role was beneficial, but it also led me to comparisons of cattle and humans as patients. In fact, I often failed to resist making such comparisons while speaking with my human patients, usually leading to annoyance on the part of the patient. What was to me a valuable analogy seemed almost always to be interpreted by the patient as an insult!

On leaving active family practice, I turned my attention full-time to the care of cattle, moving with my wife to the farm. My son, Rod, and his wife were already living on one of our farms, and together we are raising cattle. As I shared my animal husbandry experience with my friends in medicine, they began to tell me that I had not really left the practice of medicine, that these animals were my patients since I control their nutrition and mating, administer immunizations and medicines, perform various surgical procedures and derive satisfaction from my relationships with them. I believe they are right in many ways, but there are differences as well as similarities.

I admit to needing to be needed by my cattle, as well as by human patients. I derive satisfaction from feeding cattle on a cold winter day, providing shelter, treating those which become ill and rejoicing when they recover. The delivery of a new calf seems eternally miraculous to me, as does human birth. Watching calves grow and mature delights me. I grieve over the loss of one by death or often mourn the sale of an old friend who has served me well. I become very frustrated and even angry when they resist me in my efforts to do for

them what I think best. The similarities to the practice of family medicine are abundant.

As a residency director, I continually strove to help residents recognize that patients did not belong to them. Rather, the resident, as the patient's physician, was the employee of the patient. On occasion, I feel owned by the cattle instead of vice versa. However, there was no monetary satisfaction derived by me in the few cases in which I felt compelled to terminate my relationship with a human patient, but at least I can sell a cow that is especially irritating and uncooperative.

I greatly enjoy, and cannot avoid, observing similar traits, both charming and aggravating, in persons and cattle. These observations are not intended to defend any idea that persons and cattle are equivalent, nor to defend any paradigm. These thoughts are anecdotal, empirical, intuitive and pragmatic. They are not derived from controlled experiments and do not purport to be irrefutable scientific evidence. But, if the shoe fits. . . .

An experience with a steer (a neutered male) calf raised questions for me regarding origins of nurturing behavior and its relationship to gender and/or hormonal influence. During one spring calving season, this calf (as a yearling) was present at every birth for which we were present, and I can only assume he attended those we missed. He persistently hung around any cow in labor and appeared to want to assist the cow after delivery in licking her calf clean and caring for the calf in the immediate postpartum period. After a few hours he went on his way, but during that initial time he was steadfast in his attendance.

This animal was neither female nor male, exactly. From where did his nurturing behavior come? Was it due to some hormonal alteration? Why have we never seen it in any other calf? This same animal had gorged himself in bulimic fash-

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ion on calf feed at about four months of age. He had become extremely bloated and was moribund when we found him about 9 a.m. on a summer day. We called the veterinarian, who responded promptly, though he and we feared the calf would die before he could travel the 16 or 17 miles to our place.

The vet first passed a tube by mouth into the calf's stomach to try to relieve some of the gaseous distention, but without success. He then thrust a trochar and cannula through the abdominal wall into the calf's rumen (the first compartment of the cow's stomach). Removal of the trochar still did not produce the hoped-for escape of gas and resulting decompression. This was followed by rumenotomy, which permitted removal of a large quantity of malodorous, partially digested feed, plus great quantities of gas and foam. The rumen, body wall and skin were then closed, except for a rumenostomy for continued decompression. After passing another stomach tube and pumping ten quarts of a laxative solution into the calf, the vet left, offering his equivalent of "the prognosis is guarded," which was something like "I wouldn't give you a dime for his chances."

Late that afternoon, we went back to check on the calf, which we had placed under a tree. The tree was now filled with vultures waiting patiently for the calf to die, which, to our amazement, he had not done. We loaded him onto a platform behind the tractor and took him to the corral for observation and protection from the buzzards and coyotes. We did not obtain informed consent from the mother at any point in the process. We did want her assistance in nursing him, but she protested, vigorously resisting going to him and jumping several fences on the trip to the barn.

By the next morning, he was still alive — to our amazement. Therefore, we undertook to provide him with "intensive care." We watered him by inserting a garden hose into his rumenostomy and giving him a glucose infusion (Karo syrup dumped into a 10-quart pail with tap water added), poured into the rumenostomy. In spite of all this care, he improved rather dramatically.

In a few days, he had a multitude of maggots in the rumenotomy incision, which had undergone partial dehiscence. Ignoring the fact that these maggots had done a very creditable debridement, we killed them with a disinfectant spray. The calf began to eat, and in spite of continual loss from the rumenostomy of part of his feed, he "healed up and haired over," including closure of the ostomy in less than half the time predicted

by the vet. By this time he had become known as "Old Bloat," was something of a fixture around the corrals and was weaned.

In the fall, he was placed in a barn lot with other weanling calves. But we had forgotten that Old Bloat could not handle concentrated feed. As soon as he started to eat a feed supplemented with some grain, he promptly re-bloated. Discovering his state before he was again prostrate, we penned him, caught him in a head gate and passed a garden hose by mouth. This seemed to relieve him of an abundance of gas. We then poured a pint of vegetable oil down the tube to break up any more gas into small bubbles. He recovered promptly — but what were we to do with him? We could not, in good conscience, sell him for a feeder steer; as soon as he entered a feed lot, he would bloat. There seemed only one answer: Old Bloat was destined to be eaten by us.

During the following spring calving season, he was allowed to run with the herd, which was fed no concentrated feeds until reaching butchering size, and it was during this time he manifested his nurturing nature. I offer no conclusions to explain that behavior. I have never seen it in any other steer nor any other "intact male" (euphemism for bull).

Cows do, of course, nurture their own calves but often will also engage in what appears to be nurturing behavior with others' calves on a temporary basis. Often, going to the pasture to check on the herd, we will find two or three cows off to one side with 12 to 15 or more calves around them. These mothers appear to be babysitting while others graze. I have not observed any rotational arrangements or any consistent patterns in which cows take on these duties. Yet it is reminiscent, for me, of a host of neighborhood children going to the yard of one child to play under one mother's supervision.

Similarly, we have noted that one particular cow, which we raised from a calf, very seldom is more than a few steps from her calf from the time it is born until we separate them to wean the calf. This has held true through five or six calves now. It seems it is acceptable for the other calves to "come over to play," but her offspring must stay with her.

Occasionally, if a calf is born dead or dies soon, the cow will spontaneously adopt another cow's calf. Though there may be an initial dispute between the cows, there is usually no disruption of the bonding between the biological mother and

calf. Both cows will protect and nurse the calf. Except for each mother attempting to "park" the calf in the place of her choice, we have never observed jealousy between them, and the calf seems to adapt to two mothers readily. With the "double rations" it may show remarkable growth, and the natural mother may be given undeserved credit as a producer.

Many articles appear in cattle industry publications urging adequate nutrition for pregnant heifers (primigravida cows). These sources indicate that most calving difficulties are the result of inadequate nutrition before and during pregnancy. (However, I have yet to read an article recommending intake of milk by the heifer.)

In heeding this warning, we may have overfed our heifers. Neighbors have tried (subtly) to caution us about this. In our community, one does not presume to tell another what to do, at least not directly or forthrightly. Rather, the advice is given very tangentially, often while standing around the back of a truck with all present staring intently at the bed of the truck. On first observing these gatherings, I assumed that there must be something of great interest in the pickup bed.

When I got a chance to look, I saw only empty beer cans.

On such occasions, after much preliminary talk one rancher may say to the doc-would-be-cowman, "A fella's gotta be careful about lettin' heifers get too fleshy. He'll be pullin' most of those calves, otherwise." I have paid little attention to this advice, preferring to listen to those urging "good prenatal nutrition."

Pulling a calf is comparable to delivery by forceps — more or less. It is usually accomplished by application of obstetric chains, which resemble a choke-chain dog collar, to the forelegs of the calf, attachment of handles, and then pulling by hand or by a force-multiplying mechanical device called a calf-jack. We do not have a calf-jack, lacking expertise in its use and believing we can do plenty of harm even without one.

I have read that in pulling a calf no more traction should be applied than can be exerted by one man. Men, however, come in various sizes and strengths. I often admonished residents that it was considered bad form to put one's feet against the delivery table when applying traction to forceps. However, pulling a calf requires considerable force, and we often wind up using our legs with feet braced against the cow. Sometimes less conventional methods of pulling a calf are employed. One is the use of a lariat around the legs of the calf with the other end tied to a pickup bumper. The person then pulls up or jumps on the taut rope. This is not the method of choice. Furthermore, an obstetrics book borrowed from our vet indicates that the use of horses or a tractor for traction is malpractice if done by a veterinarian — but does not say it is if performed by the animal's owner.

Obviously, the form and capacity of the birth canal require attention in their own function in cows, as in human mothers. Lacerations or rupture of the canal may predispose to prolapse of the uterus or damage to the obturator nerve(s), causing paralysis of the hind legs of the cow, often but not always temporary. Moreover, wedging of the fetus in the cow's pelvis if traction fails can make delivery by section difficult to impossible.

In a normal human delivery, the hips generally present no problem, as they follow the larger head. In cows, however, if the normal arc of the delivery is not followed (as a result of improper traction or unattended birth in a pastured cow), the angle of the calf may result in hiplock, in which the diameter of the hips causes imprisonment. I once came upon a neighbor's cow and calf, both dead

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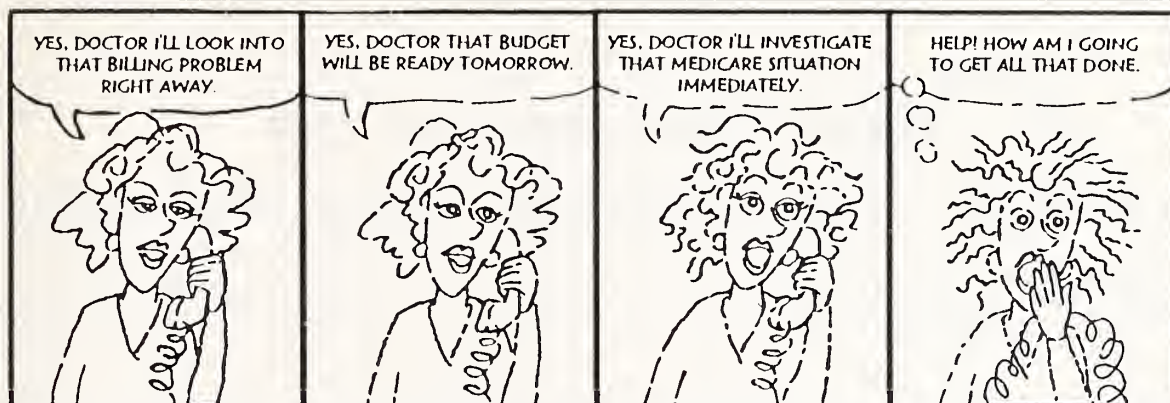
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of hiplock. The ground around was torn up to a depth of several inches by the cow's desperate thrashing. It made me ill — and highly critical of the neighbor.

It was three years later that my chickens came home to roost. Our fall calving cows were on a quarter section, and we commented for several days that we needed to move them to a more suitable site for delivery. Two calves were born there without difficulty before we could get an electric fence in place to confine the group, but we then found we were missing one cow. After an extensive search, we did find her. Her calf was in "legs back" presentation, an impossible condition for delivery, and was dead and deteriorating. It made me ill again — and angry with myself this time!

The cow was resistant to being moved but finally walked six or eight hundred yards to a point where she could be put on a trailer for a trip to the vet — easier said than done. She resisted by getting into ponds, requiring my going in after her. At last we got her to the vet, who was able to get the calf's legs out and then extracted it with a jack. The cow was unable to get to her feet, so we left her with the vet, who gave her procaine penicillin G, ergonovine, dexamethasone and tetanus antitoxin. My sleep that night was disturbed in a way identical to those times when I had worried over a human patient and the decisions I had made. Unfortunately, all our efforts were fruitless, as the cow died about 48 hours after we found her. This meant the loss of a potential \$700–800 (the price of a cow and newborn calf) and a great deal of self-recrimination.

It occurred to me to wonder whether cows have the right to refuse treatment. What would the animal rights activists say — not only about my (mis)management, but about forcing the cow to accept treatment, obviously against her will?

(Next month, Dr. Vorhees terminates his relationship with a cow whose threatening horns and bad disposition make her an uncooperative patient.)



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Patients were divided into those with normal (less than 15 mm Hg), moderately elevated (16 to 29 mm Hg) and severely elevated pulmonary wedge pressures (30 mm Hg or higher). Patients were evenly distributed between normal (19 patients), moderately elevated (15 patients) and severely elevated (18 patients) wedge pressure groups.

With increasing wedge pressures, there was a statistically significant increase in the likelihood of finding rales and jugular venous distention on physical examination, a reduced cardiac output and elevated right atrial pressure at right heart catheterization, and redistribution or interstitial edema on chest x-ray.

Intergroup differences for the presence of edema or an S₃ gallop on examination or the presence of peribronchial cuffing, hilar haziness or Kerley B lines on chest x-ray were not statistically significant, but the small sample sizes may have obscured these relationships.

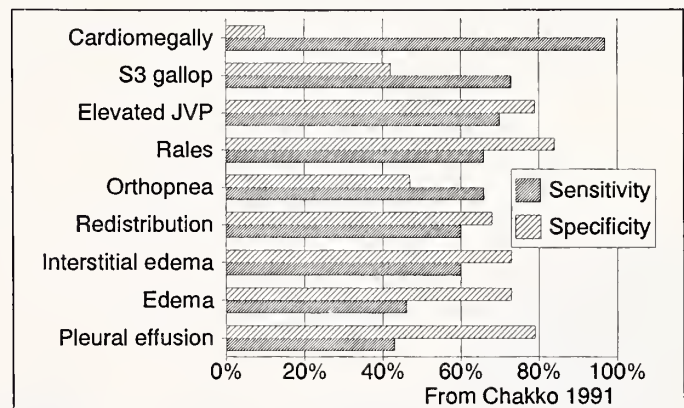


Figure 1. Prediction of PCW greater than 20 mm Hg.

The sensitivity and specificity of various findings for the presence of a pulmonary wedge pressure of more than 20 mm Hg are summarized in Figure 1. The likelihood that a patient with an elevated wedge pressure will have an S₃ gallop or elevated JVP was relatively high, but these findings were absent in nearly one-third of the patients with hemodynamic evidence of heart failure. Similarly, orthopnea, rales and radiographic abnormalities were often absent. X-ray cardiomegaly, the most sensitive finding, occurred in

TABLE 1
CLINICAL FINDINGS OF STUDY PATIENTS
(FROM CHAKKO 1991)

Mean age	49 years
Mean LVEF	19%
Duration	5.5 years
Heart rate	88
S ₃ gallop	69%
Elevated JVP	48%
Edema	38%
Rales	46%
Cardiomegaly	87%
Redistribution	41%
Kerley lines	30%
Peribronchial cuffing	25%
Hilar haziness	32%
Alveolar edema	0

*Associate Professor, Department of Medicine, University of Kansas School of Medicine-Wichita

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87% of all patients and was absent in only 3% of those with elevated wedge pressures.

In spite of a relatively strong correlation between the presence of an elevated right atrial and an elevated pulmonary wedge pressure, 25% of the patients with elevated right atrial pressures were not found on physical examination to have jugular venous distention.

Comments

It has not been shown that attempting to normalize abnormal hemodynamics is superior to simply treating the symptoms and signs of CHF. For this reason, it is unnecessary to repeatedly measure the wedge pressure in stable patients.

When a patient with x-ray cardiomegaly has a *change* in symptoms, the possibility of worsening failure must be considered, even in the *absence* of abnormal physical and chest x-ray findings.

REFERENCE

1. Chakko S, et al. Clinical, radiographic and hemodynamic correlations in chronic congestive heart failure: Conflicting results may lead to inappropriate care. *Am J Med* 1991;90:353-59.

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October 1991

Volume 92, Number 10



**First Aid for Rural Health Care
Physician to Rancher (and Back Again)**



KANSAS MEDICINE

VOLUME 92 • NUMBER 10 • OCTOBER 1991

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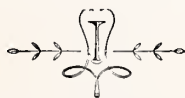
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**ABOUT OUR LOGO**

In January 1935, a new logo appeared on the cover of KANSAS MEDICINE for the first time. This device represents two stethoscopes: the original monaural type as used by Laënnec, and the modern binaural variety. The logo was designed expressly for KANSAS MEDICINE by renowned graphic designer Bradbury Thompson, a native of Topeka and friend of two former editors of the journal, Dr. W.M. Mills and Dr. Lucien Pyle. As another former editor, Dr. Orville R. Clark, wrote in January 1955, the logo "has become as much a part of the journal as any of the features on the inside and is something which is ours alone."

The caption in Jim and Sharon Hamil's *Return to Kansas* describes it as "high water on the Marais des Cygnes near Osawatomic," a simple title that points to three features of the stream in our history. First, the name (which means "marsh of swans") recalls the days when the area was "owned" by the French. Second, the high water is reminiscent of the days when the stream was prone to overflow its banks when provoked by enough rainfall. Its relatively benign behavior these days is attributed to the controls of its tributaries by the dams at Pomona and Melvern.

But historically, it recalls one of the notable events in our "Bloody Kansas" days, when some 25 pro-slavery Missourians rode in, rounded up 11 unarmed Kansans around the small settlement of Trading Post, lined them up in a ravine off the river called Dry Gulch and shot them down in what has been known since as the "Marais des Cygnes Massacre." Five of the men were killed outright, the remaining wounded but left for dead (except one unfortunate who was found still to be alive and was shot again). The survivors spread the word and gave the Free Staters more dedication to their cause (as if they needed any more).

The pro-slavery men returned to Missouri and were not apprehended. But one was captured during the Civil War, was recognized and, apparently knowing what was inevitable, begged to be hanged. His captors, however, put him through the full formality of a trial before proceeding with the course that satisfied all (including the Missourian). Justice of sorts was also served by a coincidence. One of the assassins was from Tennessee, where he owned a plantation. It happened that — entirely by accident — the Kansas Eighth was camped on that land at one point during the war. Someone who knew of the massacre recalled and made known the man's role in it. It is reported that everything on the plantation that would burn was burned. That is apparently the last act in what was called at the time "this most devilish and cold-blooded wholesale murder."

Friendly Enemy

One of the by-products of advancing age is the frequency with which one receives by mail suggestions from various quarters (especially institutions of learning) that it would be agreeable to them if we remembered them in our will. (How little do they know!) Another is the seeming increase of organizations inviting us to join them (at a price) at improving the world, local or unlimited. Such was the invitation from an organization developed by a former astronaut and inspired by his observation of "the intelligent, loving and harmonious nature of the universe."



We can certainly understand the feelings of awe that have been reported by these adventurers; we earthlings have felt some measure of that just in observing pictures, a far cry from what the real thing must be. Granted, there seems to be a certain intelligence in the universal set-up, and perhaps one can read in a degree of harmony if one can overlook a few discordant notes. But loving? We do have trouble with that. In the course of our lifetime (a minuscule point in the long range), the world has confronted directly or indirectly a considerable variety of "natural" events, anything but loving in their effect, brought on by the various elements which are the local expression of that universe.

It comes down to this: the human animal is really not too well equipped to withstand those elements, and such survival and slow adjustment as have been made have been its own adjustments, not condescensions of nature. Assaults on mankind come at every level. There are many chemical elements of structure which, we have had to learn by experience, can be highly toxic to the organism but greatly useful in some other context. There are other forms of life, from the viruses on up, that not only pose immediate danger but have great capacity to adjust to our counterefforts and become as new threats. We look with awe on our achievements of recent years — and face the agonizing frustration of contending with an agent whose hallmark is the destruction of our internal protective capabilities.

It is said that mankind carries a gene pool that is essentially unchanged in 10,000 years. That's

an eye blink to the universal pattern. But (and unless the genetic engineers can effect more rapid changes) any significant change in that human genome will continue its evolvement too slowly to mount any lasting defense against these "natural" predators. The "friendly" aspect of the universe, as expressed in our world and our environment, presents us with certain conditions, but our survival has depended upon our ability to adapt ourselves or devise methods with which to contend with modest success against this incessant pattern of assaults. That all-inclusive environment (internal and external) has, grudgingly, prompted all of our finest examples of accomplishment — physical, mental, social — with various spiritual concepts developing to sustain us along the way.

We grant that the human perspective is entirely too limited to understand the total formula that governs the universe — and, consequently, ourselves. Embryo science students are often fascinated by the humbling thought that this big, wide, wonderful world may really be only an atom (or less) in some fathomless galactic complex. (This usually turns them to other avenues of study but, fortunately, is intriguing enough to push some into trying to find out if it is true.) Since we have come to consider survival a worthy objective, that same limited perspective has inspired and guided our standards of service, intelligence and beauty and produced a certain capacity to enjoy the struggle, "enjoy" being an obviously qualified term.

At the moment, there are few subjects as prominent in the public arena as the state of the environment, the damage we do to it and the dire effects if we do not promptly mend our ways. What if we should fulfill the predictions of the most extreme of the doomsayers and destroy all early life, leaving another dead orb in the galaxy? Would the total galaxy — and all those other galaxies — care very much? We'll never know, however successful our efforts to save the earth.

Our remarks are not intentionally iconoclastic or intended to disparage such organizations as we cited in the beginning. We do need to maintain some spiritual dedication to the effort. Rather, we intend them to be a reminder that we aren't doing this for the environment and our fellow tenants. We are doing it for ourselves. D.E.G.

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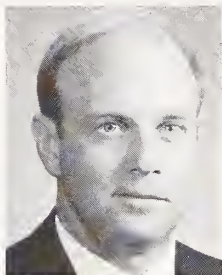


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The Future of Health Care in Kansas

On September 14, Drs. Warren Meyer, Don Brada and I represented the Kansas Medical Society during the University of Kansas Medical Center early selection process for the class of 1992. After four years of involvement in the student selection effort at KUMC, I would like to share with you two observations I made which to me show a positive trend for the future of health care in Kansas.



The first is that KUMC had 226 Kansas resident applicants for the entering class of 1988, as compared to a projected 320 applicants for the class of 1992. The second observation is that although these medical school applicants are fully aware that major changes in our health care delivery system will occur, and there is significant uncertainty about the "system" under which they will function as physicians, they are still anxious to become medical doctors. Both past and present activities of Kansas physicians and the KMS staff are related to these issues.

There are probably many factors which have favorably affected student interest in the medical profession. But I think for our Kansas students, a major factor is the improved situation in Kansas regarding the medical malpractice (professional liability) crisis of just a few years ago. During medical student interviews in 1988, medical malpractice was an issue addressed by almost every applicant, yet I did not hear it mentioned even once this year. If you recall the frustration and pain we all experienced in the 80s, you can appreciate fully that our feelings regarding malpractice were widely perceived, and that they negatively influenced the professional career decisions of our college seniors. In 1988, through the efforts of Kansas physicians, KMS staff, responsible legislators and others, the initial portion of our proposed medical malpractice tort reform legislation was passed. The fairness and constitutionality of this legislation were supported by the Kansas Supreme Court in the Samsel decision of 1990.

The Kansas medical malpractice scene was further improved when in June 1989, the Kansas Medical Mutual Insurance Company was

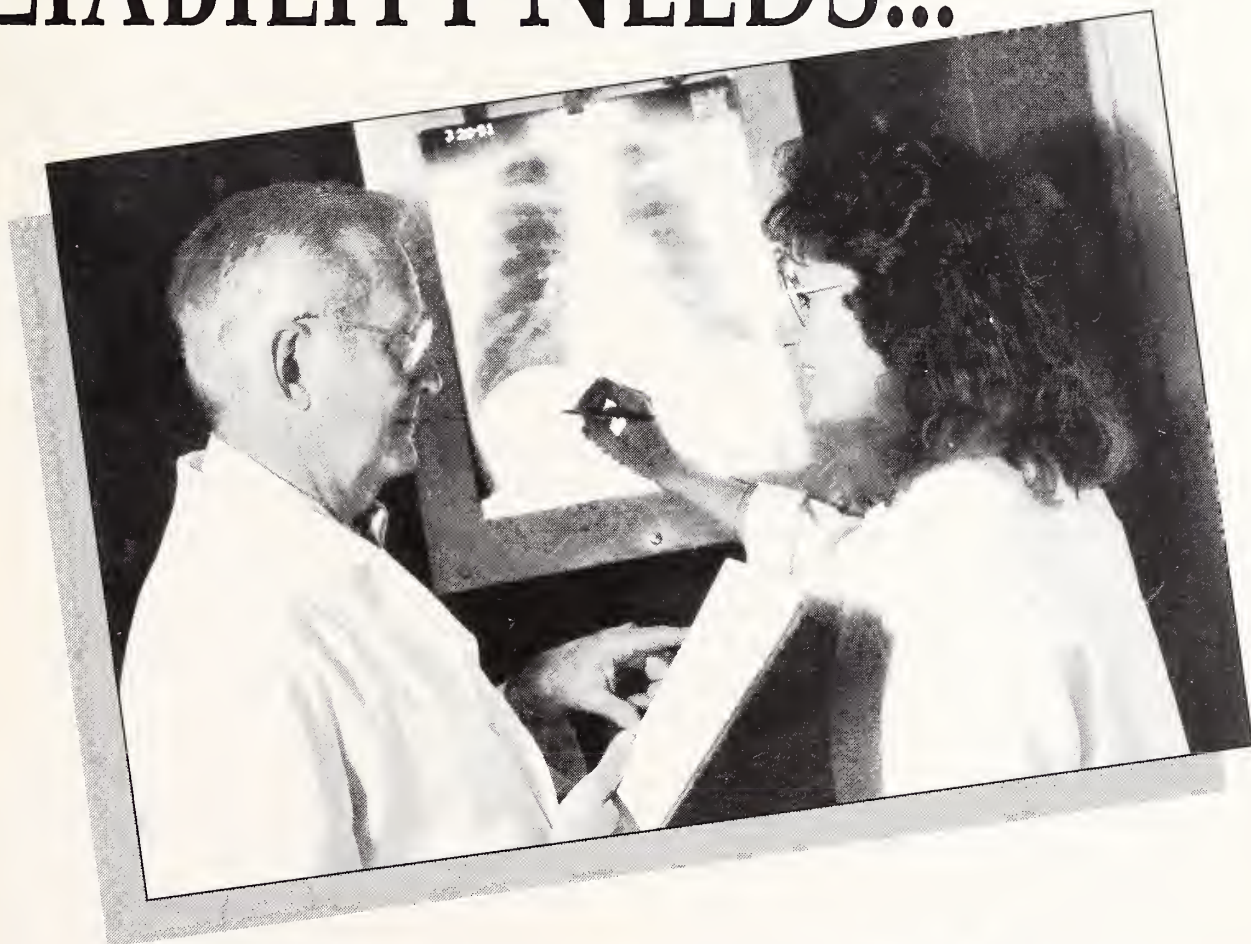
founded. Since the establishment of KaMMCO, we have all experienced a significant reduction in our malpractice premiums, and KaMMCO now insures more Kansas physicians than any other malpractice insurance company. With KaMMCO's management of the Health Care Provider Insurance Availability Plan (JUA), the company now oversees the malpractice coverage of more physicians than do the next two largest Kansas malpractice companies combined. During the first year of KaMMCO management, the JUA saved the Fund over \$1,000,000, as compared to the previous year of management by Medical Protective, and these savings will be returned to all Kansas physicians through lower future HCSF payments.

The medical school applicants we interviewed seemed to feel that every citizen should have access to health care, and many were wise enough to understand the relationship of state and federal legislative actions to health care delivery reform. The AMA has a 16-point plan known as Health Access America. Your KMS staff and officers are currently evaluating this plan and communicating with those Kansas legislative groups which will, within the next two legislative sessions, undoubtedly make significant decisions regarding health care delivery. Kansas legislators are asking for our pro-active assistance in directing necessary changes in health care. Our broad-brush initial approach will include such issues as universal access to a defined level of care, Medicaid coverage for all Kansans with incomes below the federal poverty guideline, encouraging universal employer and/or self-employed coverage (pay or play), addition of a "needs-based" concept to Medicare coverage, practice parameters and clinically based "proof of need" prior to capital expenditures for health care.

KMS members will be actively debating and clarifying the society's positions on these topics. I would encourage you to contact your councilors and delegates, write to the KMS office or, better yet, plan to attend upcoming meetings where these topics will be discussed.

Larry Anderson MD

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Of Safe Harbors . . . and Treacherous Shoals

WAYNE T. STRATTON, J.D.,* *Topeka*

It is probably no coincidence that, less than two weeks after the promulgation of the long-awaited safe harbor regulations, the Justice Department announced that it intended to devote more resources to Medicare and Medicaid fraud activities. An assistant attorney general also announced the creation of a health fraud working group to exchange information and review new developments in detecting and fighting health care fraud. The group is chaired by the Justice Department's criminal division, with representatives from the civil division, various U.S. attorneys' offices, HHS, VA, FBI and other interested agencies.



Many in the health care field hoped that the regulations would offer guidance to providers. The statutory obligation is so broad as to be capable of blanket prohibitions of commonplace contractual arrangements when it subjects anyone to criminal prosecution who knowingly and willfully offers, pays, solicits or receives anything of value, directly or indirectly, overtly or covertly, to induce or in return for the referral or arranging for the furnishing of any item or service for which payment may be made by Medicare or Medicaid. Also prohibited is receiving or paying remuneration for purchasing, leasing, ordering, arranging for such items or services or recommending any of the foregoing. Substantial civil penalties, fines and exclusion from the program for up to five years may also be imposed.

The appellate courts have broadly interpreted the statute. In one case the court indicated that if one purpose of the transaction was to induce

the referral of Medicaid business, the statute was violated. In another decision, the court required the government to prove the referrals to be the primary purpose of the arrangement. The quandary of health care providers attempting to comply with the requirements has not been addressed by the regulations.

The 11 safe harbors deal with:

- investments in publicly traded companies,
- space rentals at fair market value,
- equipment rentals at fair market value,
- personal services and management contracts at fair market value,
- sale of a medical practice to a physician,
- referral services that base fees only on operating costs and disclose to patients certain information,
- warranties,
- discounts,
- payments to bona fide employees,
- group purchasing organizations, and
- routine waivers of Medicare copayments for hospital inpatient care.

But these safe harbors represent only a fraction of the many types of arrangements in which physicians may be involved. If one is lucky enough to have the "bright line" guidance afforded by coming within one of the harbors, it is fortuitous. Unhappily, the chances are that such an arrangement would not likely have been challenged prior to the adoption of the regulations.

Physicians must not only be aware of the risks of violation of the statute in new ventures, but must now reexamine existing contracts and arrangements. There is no grandfather clause in the regulations, and something that was illegal before the regulations continues to be illegal, with enhanced likelihood of prosecution.

Given the announced intention of the Justice Department to devote substantial resources to enforcement, and the continued ambiguity of the law, **physicians should immediately reexamine their contractual relationships with the aid of experienced and knowledgeable health care attorneys.**

*KMS Legal Counsel.

Comments appearing herein are not intended as a substitute for legal analysis or advice. Answers to legal questions depend largely upon the particular facts of a case. The reader is urged to consult an attorney for answers to specific legal questions.

These comments do not necessarily represent the views of KANSAS MEDICINE, or the Kansas Medical Society. For further information, contact Mr. Stratton, 515 S. Kansas, Topeka, KS 66603, 1-800-332-0248.

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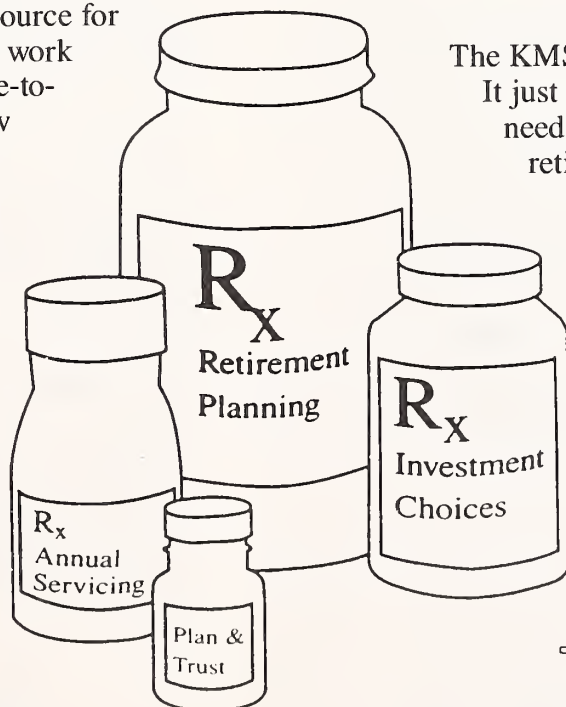
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MEETING THE NEED FOR RURAL HEALTH CARE

The Primary Care Bridging Plan

JOSEPH C. MEEK, M.D.,* AND
LORENE R. VALENTINE,† *Wichita*

Rural communities are facing shortages of all types of health care personnel. These shortages, in turn, affect access to health care services. The greatest need in rural Kansas is for primary care physicians, including those in family practice, general internal medicine and pediatrics. Sixty-nine of the state's 105 counties have been identified as underserved in primary care. Competition for physicians is very stiff because, nationwide, there has been a decrease in the number of medical students who choose primary care as their medical specialty.

In order to ensure that basic medical services will be available in rural communities, the supply of family physicians, general internists and pediatricians must be substantially increased, and there must be a concerted effort to increase the number of these specialists who are willing to practice in rural communities.

Simply increasing the total number of physicians in the country will not solve this problem. The needs of rural Kansas will not be met unless there is an adequate supply of physicians who are receptive to and appropriately trained for the challenges and opportunities of practice in a rural community.

The University of Kansas School of Medicine-Wichita (UKSM-W) recognizes the need for additional primary care physicians in the state of Kansas and supports changes in educational programs for undergraduate students and residents that will better serve the needs of rural Kansans. In order to address this need, the school has been awarded a \$600,000 Primary Care Bridging Plan grant by the Wesley Foundation. The objectives of the plan are to encourage medical students to select primary care residency programs, and to encourage physicians to practice in rural Kansas communities upon completion of residency training.

*Dean, UKSM-Wichita.

†Director, Office of Rural Health Education and Services, UKSM-Wichita.

Address correspondence to Dr. Meek at UKSM-Wichita, 1010 North Kansas, Wichita, Kansas 67214.

How the Bridging Plan Works

Residents in family practice, internal medicine, pediatrics and psychiatry programs in Wichita, Salina and Kansas City are eligible for the Bridging Plan. Applicants must have completed one year of postgraduate training in their primary care specialty and be eligible for an unrestricted Kansas license. Residents may enroll at any time during their second or third years of residency, and they can enroll in the plan and receive funds from UKSM-W before matching with a Kansas community. After they match with a community, the community portion of the incentive will be implemented. The financial incentive, along with the practice obligation, is prorated on a month-to-month basis.

During the final two years of a residency program, participants will receive the regular resident salary plus a loan of up to \$10,000 per year. In addition, the resident will receive a loan of \$6,000 upon graduation and a guaranteed, competitive salary during the first two years of community practice.

Residents must agree to practice year-for-year in the designated community and complete a one-month rural rotation during their residency program. The loans will be forgiven as the service requirements in the community are met.

A resident who has been a recipient of a Kansas Medical Scholarship is not eligible to receive a Bridging Plan loan if the terms and provisions of the Bridging Plan do not allow the resident to satisfy his/her service obligation for the scholarship program. Those who choose to practice in the greater metropolitan areas of Wichita, Topeka and Kansas City are also not eligible.

This plan has been well received by residents and communities. Since the program started in January 1991, 13 residents have enrolled. Mary Campbell, M.D., the first resident to participate in the Bridging Plan, started practice in Oberlin in July after graduating from the UKSM-W Family Practice Residency Program at St. Francis Regional Medical Center in Wichita. Dr. Campbell has acknowledged that the chance to receive extra

money through the Bridging Plan was the needed incentive for her to practice in Oberlin.

Of the 13 residents in the plan, six have already selected communities. Two family practice physicians began practice this summer: one (Dr. Campbell) in Oberlin (Decatur County), and one in Clay Center (Clay County). An internal medicine physician opened an office in Halstead (Harvey County), and a pediatrician began practicing in Ft. Scott (Bourbon County). One family practice physician will be going to Beloit (Mitchell County) and one to Lyons (Rice County) upon graduation next summer. The other residents now enrolled in the Bridging Plan are evaluating communities and practice opportunities.

In order to recruit residents, accurate and complete information about the communities is needed. The Office of Rural Health Education and Services at UKSM-W has developed and implemented a Medical Community/Practice Opportunity Profile, which has been distributed to all hospitals in Kansas. These profiles, along with the Kansas Department of Commerce's Community Profile and other recruitment information, are made available to residents who are looking for practice sites in Kansas.

One goal of the Primary Care Bridging Plan is to stimulate interest in rural health care and enhance rural health education of medical students and residents. Last spring, UKSM-W hosted a rural health workshop for medical students to provide information concerning a rural medical practice for third-year medical students prior to their clinical preceptorship rotations. Rural practicing physicians Larry R. Anderson, M.D., Wellington; Ferrill R. Conant, M.D.,

Smith Center; Craig A. Concannon, M.D., Beloit; Thomas C. Simpson, M.D., Sterling; and Gregory M. Thomas, M.D., McPherson, presented the program, and additional workshops and programs are being planned.

Another goal of the Bridging Plan is to increase the number of continuing medical education programs in the state. To this end, the University of Kansas School of Medicine-Wichita sponsored a continuing medical education program entitled "Rural Health Care: Medical Education Strategies," on September 28. Physicians who participate in the preceptorship program were invited to this conference, which focused on the future of rural health care and educational strategies to encourage physicians to practice medicine in rural areas. Medical education from the practicing physician's viewpoint was addressed during a panel discussion.

Redesigning Rural Health Care Delivery

A third goal is to develop a collaborative practice between UKSM-W and a non-metropolitan community as a demonstration of regionalized health care. To this end, UKSM-W has participated in the development of the Essential Access Community Hospital (EACH) concept, which offers the state an opportunity to redesign rural health care delivery. Two types of hospitals cooperate within the EACH program: larger, full-service hospitals (EACHs) provide certain medical and non-medical support services to smaller Rural Primary Care Hospitals (RPCBs) and their patients. The RPCB and EACH facilities are formally linked, establishing a rural health network. [See the article on page 243. — *Editor*]

An EACH network can be the focal point for the rotation of medical and health professions students to regional settings, and from there to more rural sites; the training and/or the rotation of primary care residents; and the support of practitioners through continuing education, consultative services, technical assistance activities, library and information delivery services and other specialized programs.

Implicit in the Primary Care Bridging Plan is the assumption that the exposure of students and residents to rural practice helps to increase their awareness of and interest in opportunities for rural practice. There is also the tacit belief that programs such as this plan help to reduce the professional isolation of the practitioner in these rural locations, making it more likely that the sites can recruit and retain practitioners.

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THE EACH CONCEPT

Part I: The Basics

MELISSA HUNGERFORD* AND TOM C. SIMPSON, M.D.†

In 1989, Medicare received the authority to examine and react to the costs of providing health care in small rural communities. The resulting EACH Concept was designed as an option that combines resources into a network which can benefit everyone. In general, the concept designates small rural hospitals as Rural Primary Care Hospitals or RPDHs that are linked with larger supporting hospitals designated as Essential Access Community Hospitals, or EACHs. This linkage creates a relationship that results in a rural health network.

Kansas became interested in this additional option for a number of reasons. We have growing numbers of sparsely populated areas, and almost two-thirds of Kansas' counties are expected to lose some of their population by the year 2000. A high proportion of elderly or Medicare recipients is also a characteristic of our state.

While the population declines, so does the ability to render and receive traditional acute care. More than one-third of the hospitals in Kansas average fewer than six acute-care level patients per day. Well over half of the counties in Kansas have been designated medically underserved areas for primary care by the University of Kansas Medical Center. Difficulty in recruiting and retaining primary care physicians and allied health personnel is a problem in our rural areas.

The Kansas EACH Project was initiated to study the feasibility of improved and alternative rural health delivery options. The first task of the project was to evaluate the applicability of the Essential Access Community Hospital concept and design a model that met Kansas' needs. At the core of the Kansas EACH Project are the members of the Technical Advisory Group (TAG) who represent broad-based constituencies that would be affected by a change in the rural health delivery system. The TAG functions as a voluntary, non-governmental working body to

develop and test models that meet specific Kansas needs. As a result of the TAG's work, Kansas applied for and received a federal grant to go forward with implementation of the concept. Kansas is one of only seven states to receive such a grant.

Following is a series of questions and answers which may clarify some of the basic provisions in the federal legislation and the Kansas model as it is currently envisioned.

What is the Essential Access Community Hospital concept? The EACH concept was established as a federal program through the Omnibus Budget Reconciliation Act (OBRA) of 1989 and funded in OBRA 1990. It provides for two basic programs. First, the EACH concept is a program of Medicare which allows designation of acute-care facilities as EACHs (Essential Access Community Hospitals) and RPDHs (Rural Primary Care Hospitals — referred to as "peaches"). This program establishes new "conditions of participation" for RPDHs to participate in the Medicare program and provides reimbursement incentives for both EACHs and RPDHs in return for their participation. This is a permanent program established in legislation and operated through regulations to be promulgated and monitored by the Health Care Financing Administration.

The second program is a program of grants, which are provided to seven states and the facilities within those states to design and implement the EACH concept. Kansas is one of these states.

What is a rural health network? In Kansas, a rural health network is a relationship among Rural Primary Care Hospitals, supporting hospitals/EACHs, and health care providers and practitioners. The federal definition is currently limited to RPDHs and EACHs.

A rural health network is required to establish formal agreements which set forth protocols for patient treatment, referral and transfer. The formal agreements must also establish processes for communication. This includes plans for communication among network facility administrations,

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“In Kansas, a rural health network is a relationship among rural primary care hospitals . . . and health care . . . providers.”

medical staffs and boards, as well as the transmission of patient data. Formal agreements also describe how the emergency medical services system will function within the network of an emergency medical services plan. The plan accounts for emergency and non-emergency transportation and communication from provider to provider and as a 24-hour patient access communication system. And finally, the formal agreements describe how quality assurance, peer review, risk management and credentialing will be handled.

Specifically, what is a Rural Primary Care Hospital? A Rural Primary Care Hospital (RPCH) is by definition located in a rural area. Prior to conversion to a RPCH, the hospital must have a Medicare participation agreement in effect, or have closed within 12 months of the time of conversion to a Rural Primary Care Hospital.

The Rural Primary Care Hospital has a primary relationship with one supporting hospital. That hospital may be an EACH, a rural referral center, or an urban hospital that meets rural referral center criteria.

It is the responsibility of the RPCH to select its supporting facility, which must be located within a 75-mile radius. While a primary relationship with one supporting hospital is required, a RPCH may have referral or other types of relationships with other hospitals as necessary.

As a Rural Primary Care Hospital, the facility will be reimbursed on a reasonable cost basis through the Medicare program. For inpatient (Part A) services, the facility will be reimbursed on a per diem basis, as determined by its first-year costs. For outpatient (Part B) services, the facility may choose between the traditional fee-for-service structure or an integrated reimbursement method which incorporates both the facility and professional components of the cost of service.

A Rural Primary Care Hospital must offer

emergency services through an emergency room during posted hours and via the network outside of posted hours. Kansas RPCHs may, at their discretion, provide 24-hour emergency room care on-site. RPCHs must have holding/stabilization services, which include the ability to render definitive primary care treatment prior to transfer to a supporting facility. In addition, a Rural Primary Care Hospital must provide ambulatory care services and provide for ancillary services such as radiology, lab, pharmacy, dietary, etc.

In addition to the required services, Rural Primary Care Hospitals may choose to offer low-risk obstetrics and outpatient surgery (both for less than 24 hours); long-term care, including swing-beds; home health; physical therapy; and respiratory therapy.

A Rural Primary Care Hospital may not offer inpatient services to patients who require those services for longer than 72 hours. There is, however, an exception for authorizing extensions in specific instances. And these facilities may not offer inpatient services for more than six acute patients.

What is a supporting hospital/EACH? There are two types of supporting hospitals. First, a hospital supporting a RPCH may be a designated Essential Access Community Hospital. This facility must be rural and must be more than 35 miles from another EACH, a rural referral center or an urban regional referral center. If the facility has fewer than 75 beds, the facility must be 35 miles from any non-RPCH hospital. An EACH is treated as a sole community provider, with reasonable costs covered when they result from participation in a rural health network.

A facility that is not an EACH may also support a RPCH. A non-EACH supporting hospital must be a rural referral center or an urban facility meeting rural referral center requirements. These facilities do not receive any additional reimbursement. Other facilities may have relationships with RPCHs or participate in a rural health network, but they may not be a primary supporting facility to a Rural Primary Care Hospital.

Any EACH or non-EACH supporting facility must be a full-service facility offering complete obstetrics, inpatient surgery, a 24-hour emergency room staffed by physicians, and medical/surgical intensive care and/or coronary care.

Are there any operating rural health networks in Kansas? During the federal grant application

process last spring, 24 Kansas community hospitals and two Oklahoma hospitals organized into eight rural health networks, which included 17 potential Kansas RPHs, and seven potential EACHs or supporting hospitals. Federal regulations and state enabling legislation are required before the program can be fully implemented. To date, these regulations have not been published.

The Kansas EACH project and the 26 participating facilities believe that the Kansas model has the potential to be a positive alternative to the current system of rural health delivery for some communities. It is not the right choice for all communities. Until the federal policies are documented in proposed and ultimately final regulations, many questions remain.

"Part II: Implications for Physicians" will be published in the November issue of KANSAS MEDICINE.

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Communications with Kansas Physicians

JAMES G. PRICE, M.D.,* AND ROGER O. LAMBSON, Ph.D.,† *Kansas City*

The University of Kansas Medical Center, as a tax-supported state institution, should be available as an educational and communications resource for all of Kansas. But the location of the two medical school campuses at Wichita and Kansas City, in the eastern half of the state, places them at a considerable distance from the physicians in the western half, a fact that complicates the acquisition of continuing medical education (CME). The distance may also be a hindrance to the transfer of patients to the campuses for consultation.

A medical center communications committee has considered various ways in which the campuses might be useful to the medical population of the entire state, either as referral centers or as information sources. The first step in this process was to determine by means of a survey how the physicians of the state believe the University of Kansas Medical School branches could best serve them. This paper contains a partial report of the results of this survey.

The rapid development of affordable electronic transmission of data and text during the past few years has to some extent lessened the problem of distance. Data and two-way video can be instantly available, as can live teaching conferences and other forms of continuing medical education. However, the degree to which a medical community wishes to utilize any of these communication modalities depends upon many factors in addition to distance. Practice habits, study patterns, established professional liaisons, propinquity of major centers in adjoining states, demography of the practice and the image of KUMC, as perceived by the local medical community, all help to determine how and if the state's medical centers can be of use to them.

The Survey Audience

The survey audience consisted of members of the

Kansas Medical Society and the Kansas Association of Osteopathic Medicine. Although it was recognized that in neither case would the survey reach all M.D.s or D.O.s in the state, it was believed that the group would be representative, as to both specialty and geographic distribution.

Of the 5,781 individuals then holding licenses to practice in Kansas,¹ 3,685 of them (64%) were residents of Kansas. One thousand nine hundred and thirty-seven M.D.s (53%) of these Kansas residents were members of the Kansas Medical Society. (Since the survey document asked how KUMC faculty could be helpful to *other physicians* throughout the state, any physician who indicated full-time association with the University of Kansas was not mailed a questionnaire.)

Two hundred and sixty-four responses were received (12.4%). All responses were recorded in a database² with the exception of the two questions which required extended textual answers.³ These responses were recorded separately, using the ID numbers assigned each respondent.

The state was arbitrarily divided into five regions (see Figure 1). The first four represented rough quarters of the state. The fifth region consisted of all counties having a population of 50,000 or more. This division was done in order to assess variations in answers between the urban and rural cohorts. Although a signature on the form was optional, the majority of the respondents did sign it.

The questionnaire asked for identification of the county in which the respondent lived and practiced, the size of the medical community, the number of beds in the hospital, physician specialty, and ways in which the respondent believed that KUMC might be of assistance to him or her. There were also questions relative to personal computer and modem availability, and to interest in utilizing personal computers for communication with the medical centers.

Respondents were queried as to whether the hospital they used had need of assistance with emergency care, and whether hospital personnel, other than physicians, might benefit from on-site electronic communication. The final question in-

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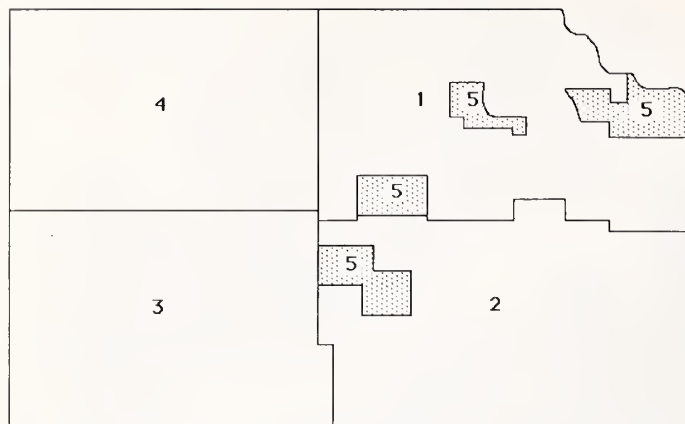


Figure 1. Those counties having a population of more than 50,000 are grouped together as Region 5. They include Sedgwick, Reno, Saline, Douglas, Johnson, Leavenworth and Wyandotte counties. These are considered as the "metropolitan" areas of Kansas, with the remainder of the state being considered rural for the purposes of this survey.

cluded space for any general comments by the respondent.

Results

One related question asked the respondents whether or not any type of communication link to KUMC might be of assistance to them. Eighty-three answered "Yes," and 62 answered "No." The remainder of the respondents did not answer the question. However, many of those in this latter category, in response to the second portion of this question which requested specific ways that KUMC might help, did offer suggestions.

Space for a written paragraph was allowed so the respondents could describe the types of help they perceived as desirable. Using a search program which looked for key words that were noted to recur,⁴ 74 responses were retrieved which broke down into the categories of televised conferences, more consultations (also included was the recurrent admonition for KUMC to be more

timely in providing information to referring physicians), on-site consulting teams, and electronic library access, particularly as regards literature searches.

Of the 74 responses, 15 were from physicians utilizing hospitals of 200 or more beds; 16 were from physicians working in hospitals of 100 to 199 beds, and the remaining 43 were from physicians using hospitals of under 100 beds. Thirty of the responses were from individuals who indicated that the staff of the hospital which they used had 25 or fewer physicians. Almost half of the individuals who suggested one or another way in which KUMC might help were from region 5 — the counties of 50,000 or more population.

Inasmuch as the survey mailing list had been limited to physicians, it was considered important to explore the possibility of hospital personnel other than the medical staff needing educational assistance. Over half the answers (as given by physicians) suggested that the nurses could utilize on-site CME, and many of the responses were that "all" hospital personnel could use it.

The question inviting comments drew a wide variety of answers, ranging from citing specific KUMC physicians for excellent consultative service, to noting that Denver is geographically much closer for ease of referrals.

Personal Computer Information

Of the 264 respondents, 164 (62%) indicated that they currently have access to a personal computer. Of these, 145 are office-based, 123 in the home, and 77 in the hospital. Several respondents have access to computers at more than one site. Ninety-six respondents indicated some interest in utilizing an electronic bulletin board, and 60 of them currently have modems.⁵

Thirty-one respondents indicated access to an Apple computer while 8 had access to an Atari, Commodore or other make which might possibly not be compatible with IBM or Apple Macintosh operating systems. Ten individuals had access to both Apple and IBM microcomputers. The 142 respondents having IBM (or IBM clone) access make this the predominant type in this audience. It should be noted that communication between IBM (MS Dos) and Apple hardware is not only feasible but commonly achieved.

Computer Interest by Region

The number of physicians in each region who have access to computers varies directly with the size of the physician population. However, the

TABLE 1
THE NUMBER OF RESPONDENTS FROM EACH REGION WAS AS FOLLOWS:

Region	Number of Respondents
1	31
2	51
3	28
4	17
5	137
Total	264

TABLE 2
THE RESPONSES BY SPECIALTY AND REGION
ARE AS FOLLOWS:

Specialty	Region					Total
	1	2	3	4	5	
FP	19	26	13	8	23	89
Gen Surg	3	5	4	0	8	20
Int Med	2	5	1	1	23	32
Ob/Gyn	0	1	1	0	10	12
Gen Ped	0	0	0	0	12	12
Ortho	1	3	3	2	6	15

(All other specialties reporting included less than 12 respondents each.)

percent of those owners who have definite or possible interest in a computer linkage to KUMC tends to be greater with increased distance from centers of population density (see Table 3).

Discussion

This survey was undertaken in order to ascertain just what types of educational assistance the practicing medical community perceives as needed, and how KUMC might meet those needs. It is clear that utilization of electronic means of providing this in the practitioner's community is highly desired. Live televised conferences, access to library facilities, and personal computer linkage to consultants and to other information resources are the prime examples of types of educational assistance desired by respondents. The concept of using two-way video communications to facilitate emergency care was attractive to many respondents, but the technical, logistic, financial and medico-legal aspects of this must be explored. Requests have been made to the university to provide definitive care via two-way audiovisual hookup to discrete practice populations in order to help relieve overburdened local physicians from night calls.

Respondents also emphasized that the KUMC consultants must provide their services to the private medical community in a fashion which is

competitive with the private sector in terms of access, promptness and congeniality.

In attempting to provide "outreach" medical education, the uneven geographic distribution of physicians by specialty must be kept in mind in order to tailor the educational offerings to the needs and desires of each physician. The decision as to the general educational topics to be covered should be that of the audience, rather than the teacher.

Computer Linkage

Using the responses of this survey to extrapolate the total number of Kansas physicians having interest in computers is subject to error, since there is variation in the number of practicing Kansas physicians as reported by the several available sources for such statistics. However, this study suggests that more than half of the physicians in Kansas have access to a personal computer, and the majority of these physicians have some interest in the creation of an electronic link between their homes, offices or hospital sites and the medical center.

It might be suggested that since transmission of data between computers requires a telephone line, it would be simpler for one physician to call the other and directly exchange information. This is quite true, and in those instances involving a need for emergency or urgent information, no other type of communication serves quite as well. However, the majority of attempts to exchange information do not concern emergencies, and many involve sufficient data to make voice transmission impractical. Additionally, getting two busy physicians on the phone at the same time is a well known obstacle to simple and immediate communication.

Uploading or downloading (sending or receiving) a lengthy text can be semi-automated in much the same way as a home VCR is programmed to record. Compression of data, so that twice as much can be transferred in any given time is frequently done. This capability is a function of readily available software. Timing of transmissions to hours of lowest toll charges is a common practice.

For the past two years, an electronic bulletin board, DOCTALK®, has been operating from the Department of Family Practice at KUMC in Kansas City. During an 18-month period, about 15,000 calls were received, and the bulletin board (BBS) carried about 40,000,000 bytes of medically oriented information. Most of this is avail-

TABLE 3

	Number		Percent
	Have Computer	Linkage Interest	
Region 1	16	10	63
Region 2	23	12	52
Region 3	18	11	61
Region 4	10	7	70
Region 5	96	50	52
Overall	164	90	55

TABLE 4
COMPUTER OWNERSHIP BY SPECIALTY

Members of the various specialties indicating ownership of (or access to) a personal computer are as follows:

Family Practice	47
General Surgery	14
Ophthalmology	9
Pediatrics	7
Internal Medicine	16
Orthopedic Surgery	11
Ob/Gyn	7
All Others	5 or less

able for downloading by medical professionals so that the data can be studied at leisure.

Anyone with a PC, a modem and a phone line can connect to this bulletin board. Access to the medical portion of the system is controlled by password use and system operator review. There is no charge for use of DOCTALK.⁶

Plans are underway to add text from weekly conferences of the internal medicine residents to the BBS. These conferences are excellent, cover a wide range of current medical problems, and reflect the most up-to-date medical information available. The text of conferences will be available to callers at no charge, as is true for all other DOCTALK usage, and will be in a format suitable for downloading by the physician user of a personal computer.

Library Linkage

Investigation is underway to determine the feasibility of creating telephone connections between physicians' PCs and the Dykes Library (Kansas City Campus) compact disk compilation of medical literature. This CD is now available to library users and allows for a quick survey of the medical literature of the past two years. This system provides brief abstracts of each article, rather than the complete article text. Physicians wishing access to acquire complete article text must subscribe to one of the several commercial computer information services which access the Library of Medicine

TABLE 5
LOCATION OF PERSONAL COMPUTERS (PC)
N = 164

PC in office	145
PC in home	123
PC in hospital	77
PC in all three	36
Available modem	93

(i.e., AMA-NET, COLLEAGUE, etc.), or make arrangements with the Dykes Library to obtain such information.

Another function of the electronic bulletin board is to serve as a "mailbox" between users. Messages can be directed to a specific individual or to the general public. Private messages can be retrieved only by the person to whom the message is directed.

Summary

The uneven geographic distribution of population, physicians and treatment facilities in Kansas may at times create difficulties in bringing unusual patient problems and needed medical expertise together. Technology currently exists for establishing communication links ranging from live, two-way, audio-video communication connections and computers to the common telephone. This survey indicates that the medical community has great interest in developing functional and cost-effective links. The two campuses of the medical school are working to provide better and broader communications access to the physicians of the state.

REFERENCES

1. Information from the Kansas State Board of Healing Arts, April 1989.
2. Microsoft Works Database®.
3. The column which invited the respondent to describe how KUMC might help the local medical communities utilizing electronic communication methods, and the column which invited any comments which the respondent might have about the survey.
4. Con = consult, consultation
Ref = referral
Grd = grand (rounds)
Rnds = rounds
Vid = video
Tel = television, telephone
Lib = library
5. A modem is an electronic interface which allows data typed into a computer to be transferred over telephone lines, from which, using another modem, it can be "read" by another computer. With modems and a bulletin board system, computers using different operating systems (e.g., IBM and Macintosh) can communicate directly with each other.
6. The DOCTALK phone number is 913-588-1998. There is no charge for use of this bulletin board.

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HMSS

Medicare/Medicaid Fraud and Abuse (Safe Harbors) OIG Anti-Kickback Regulations

FROM THE AMA

Editor's Note: It is strongly recommended that physicians who have existing or pending financial arrangements in or with health care entities review these arrangements as soon as possible with an attorney who has expertise in this area. There is no "grandfather"-type immunity for existing businesses. A review of the legal effects of these regulations on each specific health-care-related business arrangement in which a physician participates will minimize exposure to sanctions and demonstrate a good-faith effort to comply with the regulations on an ongoing basis. This is a summary of the regulations and is not intended to serve as a substitute for consulting an attorney. For more information on this subject, see the "Medicina et Lex" column on page 238 of this journal.

The Office of the Inspector General (OIG) may exclude any individual or entity from the Medicare/Medicaid programs that it determines has committed an act of fraud or abuse. The following practices shall *not* be treated as criminal offenses and shall not serve as a basis for an exclusion:

1. Investment Interests:

- *Publicly Traded Entity.* Must possess more than \$50 million in undepreciated net tangible assets, must be publicly traded on a registered national securities exchange and be registered with the Securities and Exchange Commission.
- *Privately Held Entity.* Must meet the following standards:
 - No more than 40 percent of the interest may be held by referring investors.
 - Investment must be offered on equal terms to all investors.
 - Investment terms must not be related to volume of referrals or other business.
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 - Must not market or furnish services differently to referring investors than to non-referring investors.
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 - Must not loan funds to a referring investor if the loan is used to obtain an investment interest.
 - The return on the investment must re-

late to the amount of capital investment of the investor.

2. Space and Equipment Rental:

The lease must be in writing, signed, for one year, with a fixed rental charge based on the fair market value of the premises or equipment rented with no tie to volume of services.

3. Personal Services and Management Contracts:

The contract must be in writing, signed, time period of employment specified if for less than one year, contract must be for one year or more, and compensation set at fair market value.

4. Sale of Practice:

The sale of a practice must be completed within one year with the seller no longer in a position to make referrals to the practice.

5. Referral Services:

The service cannot exclude anyone meeting the requirements, payment must be assessed and collected equally from all participants, no requirements on the delivery of medical services, and the selection criteria for the participants must be disclosed to person seeking the referral.

6. Warranties:

Warranties must be a replacement warranty or meet the FTC definition of warranty. Any price reduction which is a part of a warranty must be reported on Medicare/Medicaid cost reports.

7. Discounts:

A discount is defined as a price reduction based on an arms-length transaction which must be reported on Medicare/Medicaid cost reports. This definition excludes cash payments or arrangements where the buyer receives free or reduced goods in exchange for agreeing to buy other goods or services.

8. Employees:

Payment to an employee who has a bona fide employment relationship with the employer. (The definition of employee is the same as for federal tax purposes.)

9. Group Purchasing Organizations:

The group purchasing organization must disclose annually to providers the amount received from each vendor. Each purchase agreement must be in writing.

10. Waiver of Beneficiary Coinsurance and Deductible Amounts:

Hospitals may waive Medicare deductibles and coinsurance for inpatients, if there is no cost to Medicare and the waiver is offered to all beneficiaries.

Medicare and State Health Care Programs Fraud and Abuse

OIG Anti-Kickback Regulations

(42 CFR Part 1001 as published July 29, 1991 in the Federal Register)

The Office of the Inspector General (OIG) may exclude any individual or entity from the Medicare/Medicaid programs that it determines has committed an act of fraud or abuse. The following payment practices shall not be treated as criminal offenses under this section and shall not serve as a basis for an exclusion:

- I. *Investment Interests.* "Remuneration" does not include any payment that is a return on an investment interest, such as a dividend or interest income, made to an investor as long as all of the applicable standards are met within one of the following two categories:

- A. Publicly Traded Entity: Within the previous fiscal year or previous 12-month period, this entity must possess more than \$50 million in undepreciated net tangible assets and meet all of the following five standards:

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon[®] is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

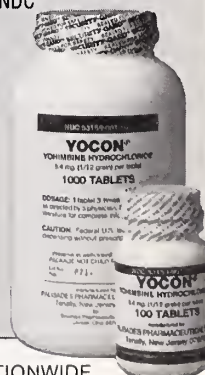
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon[®] 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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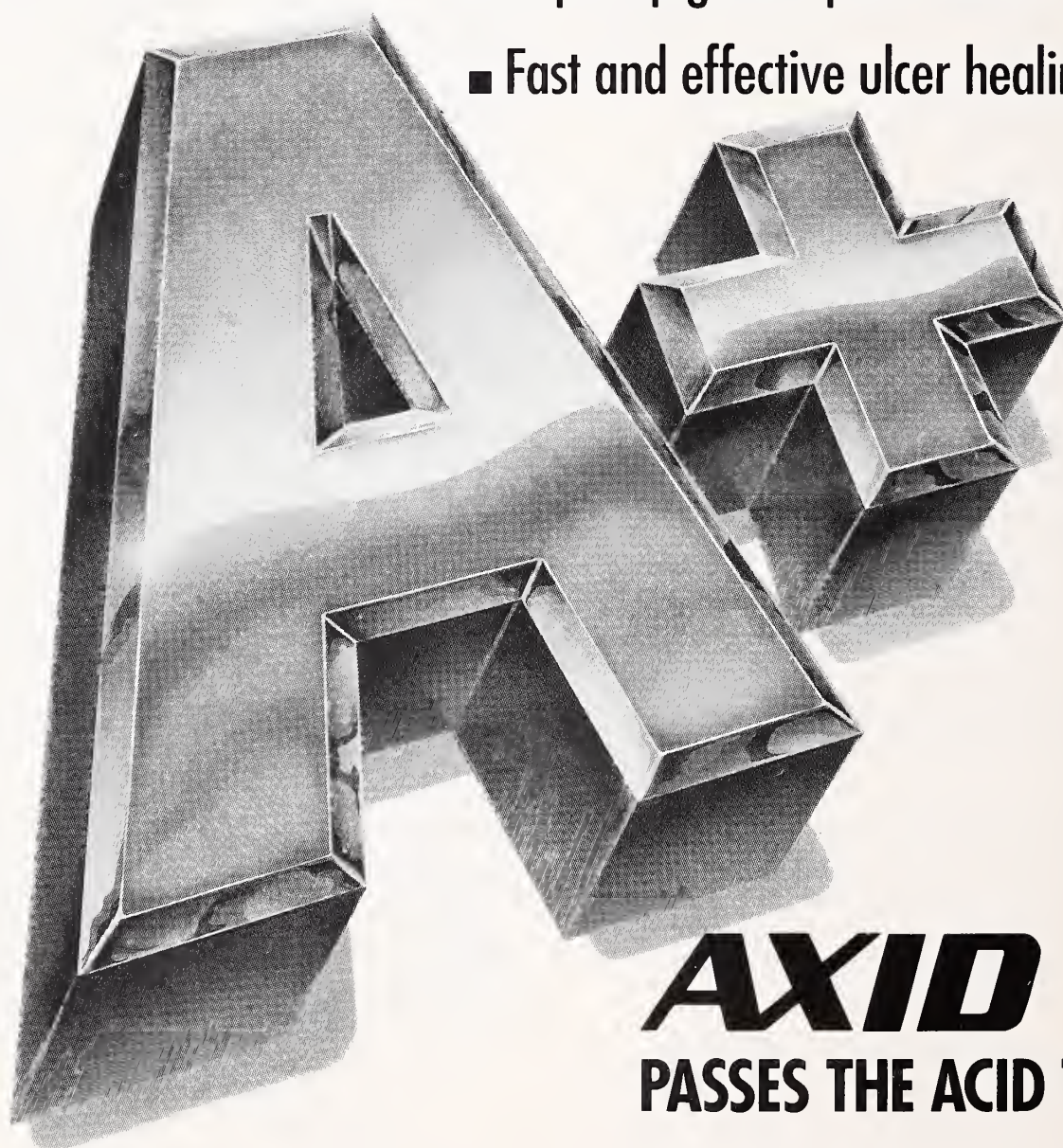
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See adjacent page for references and brief summary
of prescribing information.

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Brief Summary: Consult the package insert for complete prescribing information.
Indications and Usage: 1. *Active duodenal ulcer*—for up to 8 weeks of treatment. Most patients heal within 4 weeks.

2. *Maintenance therapy*—for healed duodenal ulcer patients at a reduced dosage of 150 mg h.s. The consequences of therapy with Axid for longer than 1 year are not known.

Contraindications: Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H₂-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H₂-receptor antagonists.

Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.
3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix® may occur during therapy.

Drug Interactions—No interactions have been observed with theophylline, chloridazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,200 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events were due to the drug.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H₂-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H₂-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis does not substantially increase clearance of nizatidine due to its large volume of distribution.

PV 2091 AMP
(091190)

References

1. Data on file, Lilly Research Laboratories.
2. *Scand J Gastroenterol*. 1987;22(suppl 136):61-70.
3. *Scand J Gastroenterol*. 1987;22(suppl 136):47-55.
4. *Am J Gastroenterol*. 1989;84:769-774.

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Additional information available to the profession on request.



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ties and Exchange Commission.

2. The investment interest must be obtained on terms equally available to the public through trading on a registered national securities exchange.
 3. The entity or any investor must not market or furnish services (or those of another entity as part of a cross-referral agreement) to passive investors differently than to non-investors.
 4. The entity must not loan funds to or guarantee a loan for an investor if the investor uses any part of the loan to obtain the investment interest.
 5. The amount of return to an investor must be directly proportional to the amount of the capital investment of that investor.
- B. Privately Held Entity: All of the following eight standards must be met:
1. Within the previous fiscal year or 12-month period, no more than 40 percent of the value of the investment interests of each class of investments may be held by investors who are in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity.
 2. The terms on which an investment interest is offered to a referring passive investor must be no different from the terms offered to other passive investors.
 3. The terms on which an investment interest is offered must not be related to the volume of referrals, items or services furnished, or the amount of business otherwise generated from that investor to the entity.
 4. There is no requirement that an investor make referrals as a condition for remaining as an investor.
 5. The entity must not market services (or those of another entity as a part of a cross-referral agreement) to passive investors differently than to non-investors.
 6. No more than 40 percent of the

gross revenue of the entity in the previous fiscal year or 12-month period may come from referrals, items or services furnished, or business otherwise generated from investors.

7. The entity must not loan funds to or guarantee a loan for a referring investor if the investor uses any part of such loan to obtain the investment interest.
8. The amount of return to an investor must be directly proportional to the amount of capital investment of that investor.

II. *Space and Equipment Rental*. "Remuneration" does not include any payment made by a lessee to a lessor for the use of premises or equipment as long as all of the following five standards are met:

- A. The lease agreement is set out in writing and signed by the parties.
- B. The lease specifies the premises or equipment covered by the lease.
- C. If the lease is intended to provide the lessee with access to the premises or to the equipment for periodic intervals of time, rather than on a full-time basis for the term of the lease, the lease specifies exactly the schedule of such intervals, their precise length, and the exact rent for such intervals.
- D. The term of the lease is for not less than one year.
- E. The aggregate rental charge is set in advance, is consistent with fair market value in arms-length transactions, and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties.

III. *Personal Services and Management Contracts*. "Remuneration" does not include any payment made by a principal to an agent as compensation for the services of the agent, as long as all of the following six standards are met.

- A. The agency agreement is set out in writing and signed by the parties.
- B. The agency agreement specifies the services to be provided by the agent.
- C. If the agency agreement is intended to provide for the services of the agent on a periodic, sporadic or part-time basis,

rather than on a full-time basis for the term of the agreement, the agreement specifies exactly the schedule of such intervals, their precise length, and the exact charge for such intervals.

- D. The term of the agreement is for not less than one year.
- E. The aggregate compensation paid to the agent over the term of the agreement is set in advance, is consistent with fair market value in arms-length transactions and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made in whole or in part under the Medicare/Medicaid programs.
- F. The services performed under the agreement do not involve the counseling or promotion of a business arrangement or other activity that violates any State or Federal law.

IV. *Sale of Practice*. "Remuneration" does not include any payment made to a practitioner by another practitioner where the former practitioner is selling his or her practice to the other practitioner, as long as each of the following two standards are met:

- A. The period from the date for the completion of the sale is within one year.
- B. The seller will no longer be in a position to make referrals to, or otherwise generate business for, the buyer.

V. *Referrals Services*. "Remuneration" does not include any payment or exchange of anything of value between an individual or entity and another entity serving as a referral service, as long as all of the following four standards are met:

- A. The referral service does not exclude as a participant any individual or entity who meets the qualifications for participation.
- B. Any payment the participant makes to the referral service is assessed equally against and collected equally from all participants, and is only based on the cost of operating the referral service, and not on the volume or value of any referrals to or business otherwise generated by the participants.
- C. The referral service imposes no re-

quirements on the manner in which the participant provides service, except that the referral service may require that the participant charge the person referred at the same rate as it charges other persons not referred by the referral service, or that these services be furnished free of charge or at a reduced charge.

D. The referral service discloses the selection criteria for participants to each person seeking a referral.

VI. *Warranties.* "Remuneration" does not include any payment or exchange of anything of value under a warranty provided by a manufacturer or supplier of an item to the buyer as long as the following standards are met:

A. The buyer must fully and accurately report any price reduction of the item (including a free item), which was obtained as part of the warranty, in the applicable cost reporting mechanism or claim for payment filed with the Department or a State agency.

B. The buyer must provide, upon request

by the Secretary or a State agency, information provided by the manufacturer or supplier as specified in this portion of the regulation.

C. The manufacturer or supplier must comply with either of the following two standards:

1. The manufacturer or supplier must fully and accurately report the price reduction of the item (including a free item), which was obtained as part of the warranty, on the invoice or statement submitted to the buyer, and inform the buyer of its obligations under this portion of the regulation.

2. Where the amount of the price reduction is not known at the time of sale, the manufacturer or supplier must fully and accurately report the existence of a warranty on the invoice or statement, inform the buyer of its obligations under this portion of the regulation and, when the price reduction becomes known, provide the buyer with doc-



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umentation of the calculation of the price reduction resulting from the warranty.

- D. The manufacturer or supplier must not pay any remuneration to any individual (other than a beneficiary) or entity for any medical, surgical, or hospital expense incurred by a beneficiary other than for the cost of the item itself.

VII. *Discounts.* "Remuneration" does not include a discount as defined by this portion of the regulation.

- A. With respect to the following three categories of buyers, the buyer must comply with all of the applicable standards within each category:

1. If the buyer is an entity which reports its costs on a cost report required by the Department or a State agency, it must comply with all of the following three standards:
 - a. The discount must be earned and claimed based on purchases of that same good or service bought within a single fiscal year of the buyer;
 - b. The buyer must fully and accurately report the discount in the applicable cost report; and
 - c. The buyer must provide, upon request by the Secretary or State agency, information provided by the seller as specified by this regulation.
2. If the buyer is an entity which is a health maintenance organization (HMO) or competitive medical plan (CMP) acting in accordance with a risk contract under the Medicare/Medicaid program, it need not report the discount except as otherwise may be required under the risk contract.
3. All other buyers must comply with the following three standards:
 - a. The discount must be made at the time of the original sale of the good or service;
 - b. Where an item or service is separately claimed for payment with the Department or a State agency, the buyer must fully and

accurately report the discount on that item or service; and

- c. The buyer must provide, upon request by the Secretary or a State agency, information provided by the seller as required by this portion of the regulation.
- B. With respect to either of the following two categories of buyers, the seller must comply with all of the applicable standards within each category:
 1. If the buyer is an HMO or a CMP, the seller need not report the discount to the buyer for purposes of this section.
 2. If the buyer is any other individual or entity, the seller must comply with either of the following two standards:
 - a. Where a discount is required to be reported to the Department or a State agency under this portion of the regulation, the seller must fully and accurately report the discount on the invoice or statement submitted to the buyer, and inform the buyer of its obligations to report the discount; or
 - b. Where the value of the discount is not known at the time of sale, the seller must fully and accurately report the existence of a discount program on the invoice or statement submitted to the buyer, inform the buyer of its obligations under this regulation and, when the value of the discount becomes known, provide the buyer with documentation of the calculation of the discount identifying the specific goods or services purchased to which the discount will be applied.

Definition Applicable to "Discount"

- "Discount" means a reduction in the amount a seller charges a buyer (who buys either directly or through a wholesaler or a group purchasing organization) for a good or service based on an arms-length transaction.

- “Discount” may include a rebate check, credit or coupon directly redeemable from the seller only to the extent that such reductions in price are attributable to the original good or service that was purchased or furnished.
- “Discount” does not include:
 - cash payment
 - furnishing one good or service without charge or at a reduced charge in exchange for any agreement to buy a different good or service;
 - a reduction in price applicable to one payer but not to the Medicare/Medicaid program;
 - a reduction in price offered to a beneficiary (such as a routine reduction or waiver of any coinsurance or deductible amount owed by a program beneficiary);
 - warranties;
 - services provided in accordance with a personal or management services contract; or
 - other remuneration in cash or in kind not explicitly described in this regulation.

VIII. *Employees.* “Remuneration” does not include any amount paid by an employer to an employee, who has a bona fide employment relationship with the employer, for employment in the furnishing of any item or service for which payment may be made in whole or in part under the Medicare/Medicaid program. (The term “employee” has the same meaning as it does for federal tax purposes.)

IX. *Group Purchasing Organizations.* “Remuneration” does not include any payment by a vendor of goods or services to a group purchasing organization (GPO) as part of an agreement to furnish such goods or services to an individual or entity as long as both of the following two standards are met:

- A. The GPO must have a written agreement with each individual or entity, for which items or services are furnished.
- B. Where the entity which receives the good or service from the vendor is a

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health care provider of services, the GPO must disclose in writing to the entity at least annually, and to the Secretary upon request, the amount received from each vendor with respect to purchases made by or on behalf of the entity.

X. *Waiver of Beneficiary Coinsurance and Deductible Amounts.* "Remuneration" does not include any reduction or waiver of a Medicare/Medicaid program beneficiary's obligation to pay coinsurance or deductible amounts as long as all of the standards are met with either of the following two categories of health care providers:

A. If the coinsurance or deductible amounts are owed to a hospital for inpatient hospital services for which Medicare pays under the prospective payment system, the hospital must comply with all of the following three standards:

1. The hospital must not later claim the amount reduced or waived as a bad debt for payment purposes

under Medicare or otherwise shift the burden of the reduction or waiver onto the Medicare/Medicaid program, other payers, or individuals.

2. The hospital must offer to reduce or waive the coinsurance or deductible amounts without regard to the reason for admission, the length of stay of the beneficiary, or the diagnostic related group for which the claim for Medicare reimbursement is filed.

3. The hospital's offer to reduce or waive the coinsurance or deductible amounts must not be made a part of a price reduction agreement between a hospital and a third-party payer.

B. If the coinsurance or deductible amounts are owed by an individual who qualifies for subsidized services under a provision of the Public Health Services Act or under titles V or XIX of the Act to a federally qualified health care center or other health care facility under any Public Health Services Act grant program or under title V of the Act, the health care center or facility may reduce or waive the coinsurance or deductible amounts for items or services for which payment may be made in whole or in part under Part B of Medicare or Medicaid.

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PART TWO

Last month's installment introduced us to Dr. Vorhees' life as a full-time rancher after his retirement from a career as an obstetrician and gynecologist on the faculty of the UKSM-Wichita. He continues his report with inevitable comparisons between human and bovine obstetrics.

In human obstetrics, one must consider not only the desire for a living, healthy child and mother but also the risk of a malpractice suit. One is not supposed to consider fees (as in a higher fee for a Cesarean section), but only the welfare of the patients.

In veterinary obstetrics, the considerations include the value of the surviving cow and calf — as well as the continuing veterinarian-client relationship. It is bad form for the fees to exceed the slaughter or salvage value of the surviving animals, at least in commercial animals (as opposed to registered stock). In small-animal practice, where pets are involved, there may be a "money is no object" attitude on the part of the client, but this does not usually apply to cattle.

Thus, the desire for living, healthy principals in the human obstetric experience has its counterpart in cattle raising. I am confident, for example, that insufficient nutrition can and does lead to weak, small calves with a poor chance for survival. On the other hand, ample to excessive feeding may lead to "fleshy" animals. For a long time, I suspected the warnings of problems in delivery of fleshy cattle were mainly an excuse for underfeeding, and that perhaps soft tissue dystocia did not exist in cattle.

Then one fall we had 12 fleshy pregnant heifers. We had "pushed" them nutritionally to try to get them big enough to breed by 15 months and to calve by 24 months. They had been given the best of pasture, plus an occasional small amount of high-protein supplement. Several of them, however, did not have as much genetic potential for accelerated growth as for obesity.

Nine of their calves had to be "pulled." One was delivered by section, and two were delivered

without assistance. By the time we had paid the tuition for this lesson, we already had 21 more bred heifers, mostly obese, due to calve the following spring. Three were sectioned, and five or six delivered spontaneously without assistance. The remainder needed various amounts of assistance, with three or four calves being pulled by the veterinarian. Heifers that are obese, with fat deposits around the tail head and lateral to the vulva, do not seem to get the amount of soft tissue relaxation ("springing") of the vulva that thinner cows do. Though I have rarely seen what I believed to be soft tissue dystocia in obese women, the degree of obesity required seems to me to be much greater than was present in these heifers.

There also certainly seems to be a variation in "attitude" toward labor among individuals and breeds of cattle, as there is in humans. I have noted that extreme anxiety can inhibit labor and indeed lead to secondary arrest. There are also those who loudly proclaim their suffering, resist the instructions of those in attendance and fail to progress normally.

So, it seems, does this occur in heifers. Some will lie on the ground, thrash about and moan, rather than push with the contractions. It is enough to make one wish for Lamaze classes for heifers. That these are not available was pointed out by a friend of my son when his wife was pregnant. He indicated his resistance to childbirth preparation classes by commenting, "You don't send a heifer to class to learn how to calve — and you sure as hell don't send the bull."

When we have a heifer in labor that seems likely to have — or is having — problems, we usually pen her for observation and possible assistance. Some go quietly and proceed with their labor but others, once penned, prefer to fight and try repeatedly to escape the pen. These heifers often

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have an apparently complete cessation of contractions and have a much more protracted labor than their calmer herdmates. I have often wondered whether sedation — a trial of “obstetric rest” — would make a difference in the course of labor or possibly obviate the need for pulling a calf or for a C-section. (I have yet to suggest this to the vets.)

The family doctor who delivered our third child told me of once being attacked by a father in the delivery room. The man apparently felt his wife’s suffering was the result of care being given her. The role of the bull in the pregnancy is obviously confined to the initial process. Therefore, I have never had any protests from bulls about my care of cows in labor — but occasionally a cow makes quite clear her animosity at my attendance.

One fall evening, I noted a heifer in labor shortly before sundown. She was an obese Limousin-Angus-Hereford cross with rather formidable horns. I attempted to pen her, as I had a premonition that she was going to have difficulty. She would not be penned. I got our hired hand to help, but even together we were unable to pen her. The vet I called had no suggestions and did not have a tranquilizer gun. Having neither skill with a lariat nor a roping horse, I sat in my pickup and watched her, trying every hour or so to walk her into the pen. At midnight, when the calf’s feet and muzzle had been showing for at least three hours without further progress, I succeeded in penning her.

In the corral I wanted to run her into a headgate (a device which catches the cow around the neck so she must stand) in order to examine her, but I could not get behind her to drive her into the alley leading to the chute and headgate. She seemed to be all horns — sending a very clear message. I hitched up the trailer, managed to run her into it and headed for the vet’s office. In town I backed up to the vet’s facility to unload the cow, but now she wouldn’t leave. I entered the trailer through a small escape door in the front, leaving the door ajar in case of a need for retreat. The cow was facing the rear of the trailer, and I popped her on the rump and shouted at her. But before I could get out, she turned and pinned me against the front of the trailer with her head. She hit me at the level of my sternum, backed off and hit me again. I was too frightened to think to cover her eyes (a trick I had heard about). Instead, I shouted, “Help me!”

The sound I heard bore no resemblance to my

“The sound I heard bore no resemblance to my own voice, as she hit me in the sternum a third time.”

own voice, as she hit me in the sternum a third time. The vet rushed to my aid with a club in his hand, but my shout had apparently frightened the cow as well. She turned, left the trailer and quietly walked into the vet’s headgate. He pulled a dead calf, with no apparent reason for failure to progress other than soft tissue dystocia. I went home with sore ribs and sternum and a new wariness about entering a trailer occupied by a cow. This troublesome creature made one more trip to town — to the sale barn as a “heiferette” (a young slaughter cow).

In human obstetrics, I had some degree of confidence in my clinical pelvimetry. Still, the only patient I ever told she absolutely could not deliver an infant of normal size did so spontaneously in the labor bed without any interference from me whatsoever. I have even less confidence in my bovine pelvimetry. After failure of a tentative pull with chains, I have taken a cow to the vet and had him pull the calf with little trouble (using a calf jack). At other times, he has agreed, after his own tentative pull, that a section is necessary.

A bovine C-section differs considerably from a human one. Today, it is usual to do the procedure with the cow standing, restrained by a headgate. Usually an epidural anesthetic is used to reduce straining by the cow, and local anesthetic infiltration is used for the skin incision. The approach varies, but our vets use a left-flank incision. The rumen can be an impediment in this approach, especially if it is full, but the intestine is usually not a problem. After opening the abdomen and uterus, the calf’s hind legs are located, the obstetric chains are attached and the calf is hauled out through the incision. This can be a tough pull, especially with a large calf.

I have found that in bovine obstetrics, as well as in human, at times everything can seem to go wrong — usually in the middle of the night. Once, during a nighttime section, after the calf was removed, the cow “went down”; that is, she went from standing to lying on the floor in a

prone position. The rumen, which was full, spilled out through the incision onto the floor, followed by what seemed to be yards of intestine. A rumenotomy was needed to allow emptying the rumen of its malodorous contents in order to make its replacement easier. The rumen was replaced, and the uterine incision was closed. Then the battle to replace the intestines began. I wound up "scrubbing" (washing my hands in a bucket of water and disinfectant that had been used to scrub the cow preoperatively, and helping to stuff the intestines (repeatedly) into the cow while the vet closed. Mother, calf, vet, my son and I all survived. This, indeed, is not the usual situation. Sections normally go quite nicely for our vets.

But cows can have problems of other sorts in delivery. As in humans, abnormal presentations occur and are potentially disastrous. The calf may come with one front leg "back," with only the muzzle and one front leg presenting. Rarely, both front legs may be back, as in my come-uppance described last month. This makes for a very difficult delivery — usually, in fact, impossible.

On one occasion, my son, Rod, was alone when he found a large Hereford cow (known affectionately as Berneice) in this condition. The vet, con-

sulted by phone, instructed him to try to push the calf back while he hurried out. Try it sometime. The propulsive force of the human uterus is a marvel, but the bovine uterus is even stronger. The vet's vehicle lacked four-wheel drive, and the ground was muddy, so Rod met him with his. They transferred the vet's equipment to Rod's pickup and returned to the corral — to find Berneice licking off a living calf.

For a calf to be born spontaneously in this presentation is unusual, but an unnecessary trip for the vet is not so unusual. Yet I have never seen a vet display disappointment when things turn out all right without benefit of veterinary intervention. In fact, I strongly suspect that benign neglect may be very useful in both human and bovine obstetrics. One of the standard obstetrics texts of the past indicates that the best treatment for desultory labor is a long, black cigar. If the physician goes outside and smokes the cigar, the patient will often be ready to deliver on his return. As in human medicine, knowing when to employ heroics and when to wait for Mother Nature is the essence of the art.

On another occasion, when Rod was gone, I found two feet protruding from a first-calf heifer,

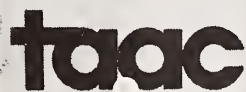
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the pads of the hooves pointing dorsally. This meant that they were hind feet, the equivalent of a human double footling breech presentation. There was a peculiar, almost eerie, feeling involved in this observation. While still about 100 yards away, I "saw" very clearly that this calf was "coming backwards." I had no doubt of it, as I approached the cow and was not surprised when I found my "vision" to be accurate. (I offer no explanation for this premonition.)

I rushed to the house for the chains, for this presentation seldom produces a live calf by spontaneous delivery. As in a human birth, once the posterior half is expelled sufficiently to compress the umbilical cord, the anterior portion must be delivered promptly to prevent asphyxiation of the calf (referred to commonly as "drowning"). The chains were not at my house, and I sped to Rod's, where I was still unable to find them. So I hurried back — to find the heifer licking off a healthy calf. I cannot help wondering if she was better off for my not finding the chains.

Unfortunately, disastrous results can occur with or without human intervention. One of our Tarentaise heifers delivered a calf unattended. Be-

cause the calf's hind legs continuously lay against its chest when the calf was undisturbed, we assumed that there had been a frank breech presentation. However, the cow appeared to have a very adequate pelvis, the calf weighed a diminutive 52 pounds (the average being 70 to 80 pounds) and a good outcome should have been possible in a breech presentation. The calf, a heifer, lacked all coordination, suggesting a degree of asphyxiation at delivery.

With a calf, such a problem is handled more directly than in a similar case with a human baby: she was euthanized after 24 hours. This calf was beautiful, and to see her thrashing about, lying in a cruciform, prone posture rather than the normal posture of flexion was heartbreaking. But before arriving at this decision, we invested 24 hours in trying to do all we could for her, including dexamethasone injections, milking out the mother and bottle-feeding the calf in our warm furnace room. Moreover, we had invested \$1,200 in the heifer when she was a young calf and now, at two years of age, she was supposed to return some of this investment. Nonetheless, the loving, humane thing to do was done. The calf's brain was sent for viral studies to see whether the problem was something other than supposed birth trauma. The autopsy report indicated intrauterine infection with BVD (bovine viral diarrhea) virus, and the cerebellum was very hypoplastic. Any cow in which we had less invested would have "gone to town," but this cow got a second chance.

We had not vaccinated our mother cows for BVD for some time and this cow had never been vaccinated, either. Adding this to our herd health program would cost, if administered by us, about 50 to 60 cents per cow per year. However, we will give a combination vaccine for BVD, IBR (infectious bovine rhinotracheitis) and PI3 (parainfluenza-3), costing a total of just over \$1.00 a dose. With our herd of about 120 cows at present, avoiding one death every two years will more than allow us to break even, as a newborn calf brings \$150 to \$250, and the cost of caring for the cow during her pregnancy may be even more. Cost-benefit ratio considerations have been around for a long time in veterinary care.

(Dr. Vorbees' experience taking care of 120 bovine patients, plus other ranch duties, takes a turn in next month's concluding episode of his adventures, in which he recounts his retirement from retirement.)



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Dr. Paul Volberding, Researcher, University of California, San Francisco, Member, American Medical Association

Amid the rancor of politics and budget debates, the needs of the patient are often overlooked. And, it is forgotten that it is physicians who know the most about disease and the suffering of patients.

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The American Medical Association (AMA) agrees. The AMA is committed to fair AIDS policies, and to supporting researchers battling not just AIDS, but the countless diseases that ravage our society.

"What impresses me most about the AMA is its

willingness to take public policy positions and its ability to influence opinion," Dr. Volberding adds.

You are invited to join Dr. Volberding and to join with him in his efforts to bring quality health care to those in need. Become a member of the American Medical Association today.

Members of the AMA are encouraged to join their state, county and specialty societies.

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Cutting Strokes Off at the Neck

DONALD L. VINE, M.D.,* *Wichita*

For many years clinicians have argued the merits of carotid endarterectomy for the prevention of strokes in patients with transient ischemic attacks. A recently reported trial seems to clarify the indications for surgery.

The MRC Trial

In 1981, the European Carotid Surgery Trial was initiated to evaluate the usefulness of carotid endarterectomy within six months of carotid territory transient ischemic attacks, mild non-disabling ischemic stroke or retinal infarction. After obtaining carotid angiograms, the patient was randomized to either "immediate surgery" or to "no immediate surgery" if the physician was uncertain as to which type of treatment was preferable. If the physician was "reasonably certain" that management should be either surgical or non-surgical, the patient was not randomized.

Endpoints

Surgery-associated strokes or deaths, late disabling or fatal strokes and duration of non-disabled survival were the criteria evaluated. Symptomatic patients with mild (0–30%) carotid stenosis were compared to those with moderate (30–69%) or severe (70–99%) stenosis.

By January 1991, 2,518 patients had been randomized with a surgical:medical allocation of 60:40. Interim data were complete on 2,000 of these, with a main follow-up of almost three years.

The results for 1,152 patients with either mild or severe carotid stenosis are reported in this first interim study. Patients with moderate stenosis are still being randomized.

Results

Within 30 days of surgery, 3.7% of patients with severe and 2.3% of patients with mild stenosis had died or suffered a disabling stroke.

Among patients with severe stenosis, the occurrence of ipsilateral disabling or fatal stroke among

the surgical patients (1.1%) was substantially less than that among non-surgical patients (8.4%). The difference for *any* fatal or disabling stroke was smaller but statistically significant (6 vs. 11%).

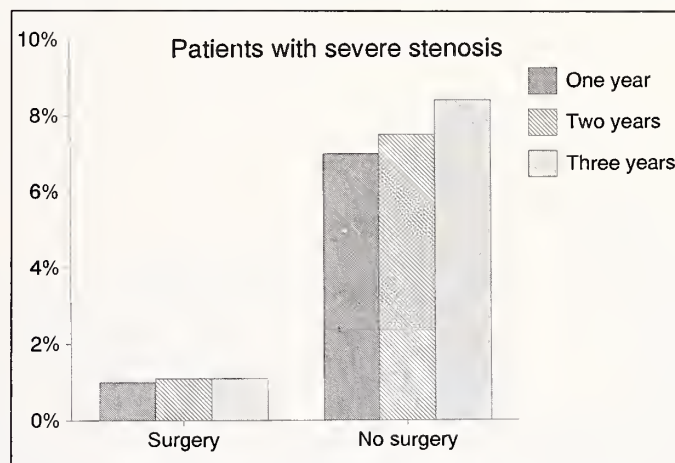


Figure 1. Ipsilateral fatal or disabling strokes.

Among symptomatic patients with mild carotid stenosis, there was no advantage to surgical intervention. One of 219 surgical patients and none of 155 medical patients experienced a fatal or disabling ipsilateral event. When all disabling or fatal strokes were counted, the surgical patients showed a statistically insignificant disadvantage (5.6 vs. 1.2%).

Comments

The authors feel that the benefits of carotid endarterectomy for symptomatic patients with 70%

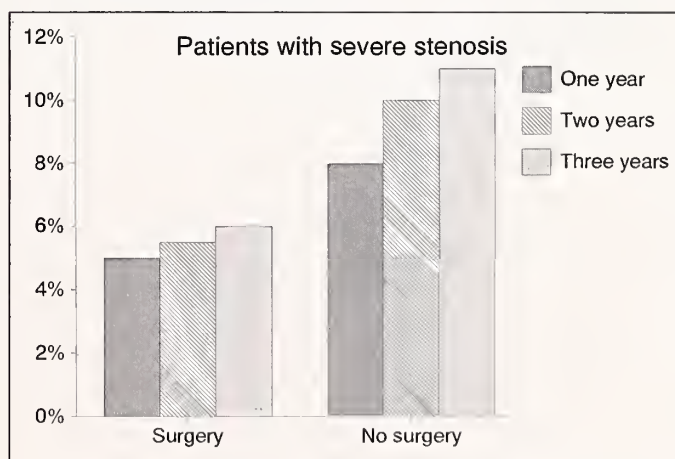


Figure 2. Any fatal or disabling stroke.

*Associate Professor, Department of Medicine, University of Kansas School of Medicine-Wichita

Address correspondence to Dr. Vine, Department of Medicine, UKSM-W, 1010 N. Kansas, Wichita, KS 67214.

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or greater stenosis of a carotid artery are substantial, and that the results might even apply to similar patients who are asymptomatic.

The selection bias inherent in this study may confuse the issue for patients with less than 30% stenosis, but surgery for symptomatic patients in this category was not found to be beneficial, and may even be harmful. To apply these results to patient care, the success obtained by the available surgical team must be known and found to be within acceptable limits.

REFERENCE

1. European Carotid Surgery Trialists' Collaborative Group. MRC European Carotid Surgery Trial: Interim results for symptomatic patients with severe (70-99%) or with mild (0-29%) carotid stenosis. *Lancet* 1991;337:1235-43.

THE WAY IT WAS

(From the Journal of the Kansas Medical Society, Vol. 13, No. 1, 1913.)

THERAPEUTIC NOTES

Try cimicifuga in spinal irritation.

Tr. pulsatilla, applied locally, is useful in ovarian pain.

Scanty menses in plethoric women may be relieved by veratrum viride.

Aspirin in a fine powder is a useful application to a follicular tonsil.

Pituitary extract or adrenalin [sic] is better than strychnia in impending collapse.

Equal parts, zinc stearate, bismuth subnitrate and starch is an excellent application for chancroid.

To disinfect stools, add one-fourth their volume of quicklime and pour hot water over it. Set aside for two hours.

For dandruff, Brayton recommends 1 drachm precipitated sulphur and 30 grains salicylic acid in an ounce of ung. aqua rosae.

Two drachms each of the official mercury, belladonna and iodine ointments and 2 drachms of vaseline is a useful application to enlarged lymph glands. — Medical Council.

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Ventricular Tachycardia in a Newborn
Special Feature: Healthy Holidays



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**ABOUT OUR LOGO**

In January 1935, a new logo appeared on the cover of KANSAS MEDICINE for the first time. This device represents two stethoscopes: the original monaural type as used by Laënnec, and the modern binaural variety. The logo was designed expressly for KANSAS MEDICINE by renowned graphic designer Bradbury Thompson, a native of Topeka and friend of two former editors of the journal, Dr. W.M. Mills and Dr. Lucien Pyle. As another former editor, Dr. Orville R. Clark, wrote in January 1955, the logo "has become as much a part of the journal as any of the features on the inside and is something which is ours alone."

Jim and Sharon Hamil identify the bridge posing for its portrait on our cover as possibly owing its form to the Romans. This is a good bet, as the Romans were into bridge-building early in the game and produced some remarkable aqueducts as well. Even so, they apparently learned how to do it from their neighbors, the Etruscans, and there must have been others somewhere who found ways to cross rivers or ravines but didn't have as good a press.

The Romans' first bridges were of wood, which was probably a good idea in the opinion of Horatius, since it is hard to say what might have happened to him if his buddies hadn't been able to chop the bridge out from under him and the Etruscans who were giving him a hard time. At any rate, the Romans tried using other materials on timber bases and then went to stone throughout.

From 200 B.C. to 260 A.D., they built eight bridges across the Tiber. It does add up to some formidable engineering, as they used no mortar, and one built for Trajan over the Tragus is still standing. Just how serious they were about this bridge-building can be drawn from the fact that the title, *pontifex*, meaning bridge builder, became part of the common language, identifying those officials charged with keeping the bridges in good repair. The headman idea resulted in the term, *pontifex maximus*, coming to refer to one of the top dogs in the civil administration, and then was applied to the chief religious functionary with no bridge-building connotation. It finally became an honorary term given to the reigning emperor.

Modern bridge builders have one disadvantage. The Romans, hoping for the goodwill of the gods, started their construction off with a human sacrifice. This became unpopular, especially with the sacrificees, and they began to substitute straw-filled dummies. Just a thought for the county commissioners confronted with irate constituents — whether irate because they want a new bridge or because they don't.

Great Expectations

The general thought is that the game of baseball is the true national pastime. Some, especially in this season, would hold out for football. We offer a somewhat different candidate for that dubious honor: taking surveys. Ever since the statisticians justified their existence by devising their chi squares and 95th percentiles, zealous folk have been dogging various segments of the populace to determine what they think or do, or what they wish they could think or do. (Or, increasingly, what someone else should think or do.)



The latest effort of this sort to catch our attention was a survey of medical residents which sought to determine their plans for their futures: location, hours, recompense anticipated, and so on. It should be noted, for advanced students of surveys, that the procedure was conducted by telephone and comprised only 100 respondents covering six medical specialties. Offhand, we might dismiss the effort as being somewhat limited in validity, but then we would have nothing to write about.

And there were some interesting points raised, if only to ponder whether they *are* valid. Since the costs of medical service are much in the news (and out of personal curiosity), we turned first to the respondents' expectations of remuneration in the first year of practice. About half expected to reach the \$75,000 to \$125,000 level. Now, this is not going to be another grumpy dissertation by one of the old goats about how it was in the old days. We have long since become reconciled to the fact that the social, economic and professional upheavals of the last half-century have rendered any true comparison between those times and the present only generically relevant. Still, it is worth noting that, while 10% anticipated less than \$75,000, the remainder of 39% looked forward to starting with more than \$125,000 a year.

There was, however, another item in the study which was an even greater surprise to us: the number of practice opportunities offered these individuals well before the completion of their training. Forty percent of the group had received more than 100 offers of practice opportunities, while 25% had more than 200. (Inevitably, this did

bring back the recollection that we had two chances after our internship, one of which was an offer from the Army of the United States that we couldn't refuse — so to speak. Bless them, however; this led to the GI Bill, which provided our major sustenance when we could pick up the other offer four years later.)

It may be, of course, that computerized offers of employment go out to residents on the order of Ed McMahon's offers of \$10,000,000 — with comparable chances of actually obtaining employment — or to all those the computer addresses as "Resident." Still, it suggests that there is a seller's market favoring these people well beyond our realization. Is unrecognized disease running rampant across the nation? Is there a dangerous shortage of physicians behind the reports of so many being unable to get medical care? Perhaps it takes so many physicians to run the technologies — or run those who run them — that the resulting reduced physician-patient ratio (in terms of direct contact) results in a massive demand. Alternatively, it may be that a great many more physicians are being utilized, one way or another, in looking after one specialized type of patient — in contrast to the archaic concept of the general practitioner.

There were, of course, many more points in the study. Of some interest to the "rural" states is the finding that 42% of the respondents wanted to practice in communities of more than 500,000 population. Seventy percent anticipated working 50 to 70 hours a week. Group practice was strongly favored, and only 8% looked forward to solo practice, a shift which called into memory the fact that 50 years ago (before the ascendancy of the Mayos, Criles and others) such arrangements were anathema. Moreover, "contract" physicians were instruments of the Devil and would likely get one removed from the rolls of organized medicine.

We've tried to pass this information on without too much intrusion of personal thoughts, but one theory has been persistent: the viability of surveys reflects their something-for-everyone approach. In this case, those aspiring to medical careers can take this as affirmation that their dedication to

(Continued on page 296.)

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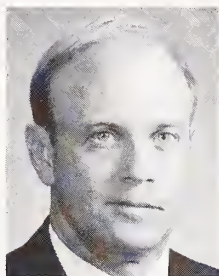
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With Privilege Comes Responsibility

It was during my undergraduate days when I finally realized the title phrase of this message was, in fact, not original with my mother. The aphorism "with privilege comes responsibility" applied well on those occasions when privileges at home, school or even church were restricted — or withdrawn — because of irresponsible behavior. But it was always frustrating when *my* privileges were restricted because of the actions of others, whether a ball team, a school class or a club.



Society has given physicians many privileges, but it seems the irresponsible actions of a few colleagues are producing marked restrictions in our privileges regarding office laboratory studies for Medicare patients. In the last several years, Medicare has made two major rulings regarding such studies, each of which, in our office, has increased the cost of Medicare-covered health care. I do not believe that Medicare administrative people are ignorant; I am convinced they are simply overwhelmed by their administrative inability to control what they feel are excessive utilization and charges for laboratory services.

The first change was the provider-only charge rule, which simply stated that a physician could no longer charge Medicare for work done by a reference lab. At that time, our office was charging \$35 for a multichem profile for which we paid the reference lab \$11. We realized this was a significant markup but felt it was reasonable, since we drew and prepared the blood for shipment, received and interpreted the lab results, paid the reference lab (even when we did not get paid) and contacted the patient, by either phone or letter, regarding the results of the profile. Often a change in therapy or scheduling of further studies was required. In retrospect, our \$35 charge may have been excessive, but we rationalized that we were charging no more than anyone else.

At that time, Medicare offered to pay a \$3 handling charge for specimens submitted to reference labs. We felt this was inadequate reimbursement for the effort described above and decided to go into the lab business ourselves. We obtained an in-office laboratory machine and started doing occasional organ-specific panels, for which we

charged \$35 to \$45 to obtain a few of the values that we used to obtain in the \$35 chemistry profile.

The second rule change seems to have been aimed directly at organ-specific panels. As of November 1, 1991, physician office labs may no longer charge for organ-specific panels, but must charge for each individual test performed. Reimbursement schedules are established so that a physician who does more than three or four tests will not receive enough reimbursement to pay for the test reagents. We never did use our office lab very much (an average of seven organ-specific panels

**"Medicare seems to have
reverted to the
ancient . . . tool of restricting
group privileges."**

per doctor per week) and have already started sending Medicare patients to the hospital — where that same initial \$35 study produces a charge of \$151 and Medicare reimbursement of \$80. Although we do not draw the blood for the hospital lab, we provide all the follow-up services mentioned above and receive no reimbursement whatsoever.

An article in the October 14, 1991 *American Medical News* reviews a study done in Pennsylvania that suggests "a relatively high percentage of the state's doctors may be 'gaming' the system to boost reimbursement." The primary abuse suggested in this report was that of unbundling. Other studies document gross overutilization, such as the physician who orders an average of six organ-specific panels on each of 25 Medicare patients seen daily. From our collective experience with professional review organizations (PROs), we understand that individual physician actions are difficult to review accurately, evaluate and modify as may seem necessary.

(Continued on page 292.)

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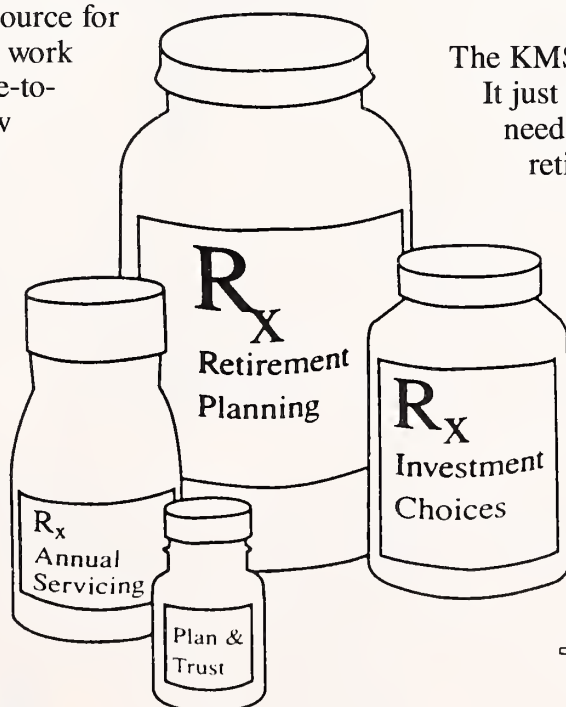
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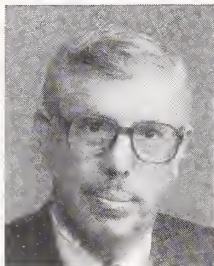
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Peer Review Revisited

WAYNE T. STRATTON, J.D.,* *Topeka*

The issue of peer review and its potential threat to a physician's emotional and financial well-being has been previously discussed. The issue is fluid and dynamic, so this article will deal with recent developments in the law of peer review.



Concern over liability has a chilling effect on the peer-review process. A 1989 AMA survey found that 25% of physicians believed they were not sufficiently protected under the law to engage in their medical institution's peer-review activities, and 15% were uncertain. The same survey found that 28% did not believe their practices were being effectively reviewed.

The most significant development in recent years is the enactment of the Health Care Quality Improvement Act of 1986. While the reporting requirements are burdensome and may be personally embarrassing, the act does contain an immunity from antitrust liability if certain procedural requirements are met. Two cases have discussed the provisions of this act, both arising from California. A California federal court dismissed a claim by a neurosurgeon who brought an antitrust action against a hospital and individual physicians for their conduct in connection with the suspension and subsequent conditional reinstatement of his staff privileges. The court noted that the concern for patient safety prompted nearly ten months' worth of both internal and external evaluations and monitoring of the plaintiff's cases conducted by the defendant neurosurgeon and other members of the surgical audit committee, as well as two neurosurgeons appointed by the California Medical Association

who had no connection with the hospital. More than 70 hours of testimony was taken at the hearings. The use of outside reviewers who had no direct economic competition with the plaintiff and the use of a hearing panel consisting of physicians who were not in direct economic competition were noted by the court.

In the other recent decision, the court allowed an antitrust action by an eye surgeon, even though it appeared that interstate commerce would not be affected. The significance of the decision is that it broadens the ability of a disgruntled physician to bring an action under the Federal Antitrust Act.

How might recent developments in the law affect me?

In the latter case, the court discussed the Health Care Quality Improvement Act of 1986. In the footnote, the court stated the physician alleged that the process did not conform with requirements of the act such as adequate notice, representation by an attorney, access to a transcript of the proceedings and the right to cross-examine witnesses:

According to the House sponsor of the bill, 'the immunity provisions were restricted so as not to protect illegitimate actions taken under the guise of furthering the quality of health care. . . . Actions that are really taken for anti-competitive purposes will not be protected under this bill.'

The United States District Court for the District of Kansas recently held that physician reviewers for the Board of Healing Arts are immune from liability, under the theory that they were acting for the benefit of the State, and thus immune under the "state action" exception to the antitrust laws.

Report DD (A-91) of the Board of Trustees

(Continued on page 277.)

*KMS Legal Counsel.

Comments appearing herein are not intended as a substitute for legal analysis or advice. Answers to legal questions depend largely upon the particular facts of a case. The reader is urged to consult an attorney for answers to specific legal questions.

These comments do not necessarily represent the views of KANSAS MEDICINE, or the Kansas Medical Society. For further information, contact Mr. Stratton, 515 S. Kansas, Topeka, KS 66603, 1-800-332-0248.

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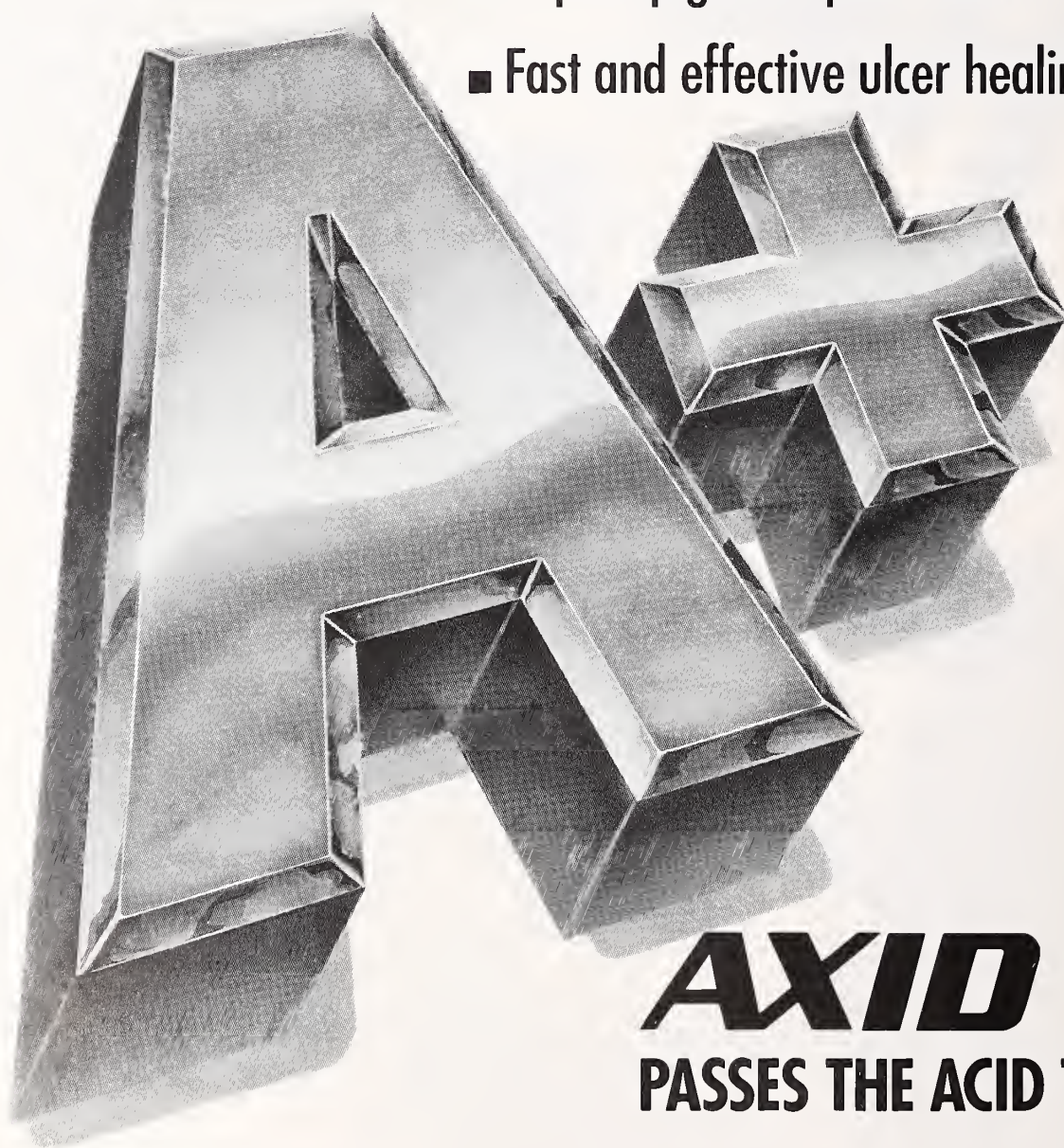


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2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix® may occur during therapy.

Drug Interactions—No interactions have been observed with theophylline, chlorazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromatin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events were due to the drug.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H₂-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H₂-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported.

Eosinophilia, fever, and nausea related to nizatidine have been reported.

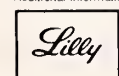
Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis does not substantially increase clearance of nizatidine due to its large volume of distribution.

References

1. Data on file, Lilly Research Laboratories.
2. *Scand J Gastroenterol.* 1987;22(suppl 136):61-70.
3. *Scand J Gastroenterol.* 1987;22(suppl 136):47-55.
4. *Am J Gastroenterol.* 1989;84:769-774.

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Additional information available to the profession on request.



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MEDICINA ET LEX

(Continued from page 274.)

of the American Medical Association extensively reviews the importance of peer review, the concerns of physicians in participating in the process and the inadequacy of the law in dealing with a meaningful review of the process. As the report notes, while the chances of successful recovery against a physician participating in peer review are remote, the consequences are so devastating as to chill enthusiastic involvement in what should be a very important and socially valuable process.

The report recommends that states consider several alternative approaches to improving the process:

a. The creation under the auspices of the healing arts board of a peer review panel, which would have the authority to hear appeals from hospital peer review committees, or alternatively, to delegate the authority to perform the initial peer review on behalf of the medical society or medical staff.

b. The state medical society, either individually or in cooperation with the state hospital association, could form a committee to hear appeals of peer review decisions from hospitals.

c. Pursuit of legislation that would create procedural protections designed to ensure fairness in the hospital peer review process or encourage hospitals to adopt bylaws with the requisite protections.

Given the degree of physician discomfort in the present process, such suggestions seem worthy of further study.

A HOLIDAY GIFT FOR YOUR PATIENTS

The annual feature "Healthy Holidays" appears on pages 288-91 of this issue. This self-contained section is written for the layman and designed so you can have copies made to give or send to patients during the holiday season. This is an inexpensive way to remind your patients of your concern for their well-being, even when they are away from your office.

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Part II: A Physician's Perspective

TOM C. SIMPSON, M.D.,* *Sterling*

Thanks to a \$3.2 million grant from the Health Care Finance Administration, Kansas has an opportunity to implement the Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH) concept in at least 26 hospitals and communities. Those of us who have been working on this project for over a year see it as an opportunity for rural communities in Kansas. Many are facing the loss of local access to health care and feel a need to change from their traditional models of health care delivery to a new concept that we believe will be viable and sustainable.

Physicians are key players in this new concept of health care delivery. It is essential that they be "on board" to participate with communities and hospitals in making decisions about networking with a neighboring medical community and developing a rural primary care hospital. Physicians will need to weigh very carefully the effects of such a transition upon their practice styles and their incomes. These decisions are made even more difficult when there are few other models like EACH/RPCH available to look at. In fact, HCFA is still developing some of the rules for these new arrangements.

The EACH/RPCH concept would not be necessary if health care in our rural Kansas communities were thriving, if there were plenty of doctors vying to set up practice in every little hamlet and if the coffers of our rural hospitals were overflowing with general payments from caring for Medicare and Medicaid patients. But such is not the case. It appears that rural communities and physicians are at a turning point in their lives. Either they continue trying to make the status quo work, or they look to new and innovative ways to accomplish health care for their people. As we read about each rural Kansas hospital that closes its doors and hear of each Kansas physician who packs up and moves to the big city, it appears that the time is right for EACH/RPCH in Kansas.

*Private practice, Sterling.

Address correspondence to Dr. Simpson at 239 N. Broadway, Sterling, Kansas 67579.

Understand, the rural health care problem is certainly multifactorial in etiology. EACH/RPCH doesn't solve all of everybody's problems. But it is one solution to the problem, and it deserves consideration. Very practically speaking, it is also a solution that the federal health care planners (whoever they are) are supporting and putting their money behind. Let's face it: that is going to make a difference with so many of the health care dollars coming out of Washington, and with the trend toward more federally financed health care continuing.

So what is it going to be like to be a doctor in a RPCH? By virtue of the fact that the hospital is going to scale back to six acute-care beds, each of which has a 72-hour stay limitation, one would assume that the hospital load will be lessened. RPCHs may still participate in the swing-bed program, so the need for periodic rounds on "swing-ers" will still be with us. RPCHs will be much better reimbursed for the care they provide, so we would look forward to some of our rural hospitals being able to replace worn-out or outdated equipment. In fact, there is money in the grant for some RPCHs to buy telecommunications equipment so that clinical consultations may be available by video.

At first glance, the 72-hour stay limitation might suggest that RPCHs and their doctors are never going to take care of anyone who is very sick. I disagree. Most of us have seen our hospital length of stays decreasing over the past 10 years, thanks in large part to better drugs and technology, not to mention the pressure from our administrators to meet DRG standards. Most pediatric admissions are short for a primary care doctor. Many of the elderly can be stabilized and "swung" in three days to continue their recovery. The patient with an acute MI seldom stays more than a day or two after thrombolysis is accomplished before a referral is made for more definitive care. A patient with a diagnostic dilemma has usually exhausted the technological capacity of a small rural hospital in two to three days, so referral is made to a secondary or tertiary center before the three-day limit is exceeded. The primary care

physician realizes that he can't take care of everyone and all of their diseases. That's why there are specialists. I would submit that there is a lot of challenging medicine to be practiced during three hospital days.

The "rules" of a RPCH allow for physician extenders to have an expanded hospital role. This may allow a physician to cover more than one hospital and possibly live in a neighboring community, yet still be the RPCH medical staff. This might be attractive to both physicians who are trying to slow down professionally and those wanting to become more active. One can envision a single doctor having patients in two or maybe three RPCHs and perhaps employing a P.A. or nurse clinician in each of those communities. The doctor may live in one of the RPCH communities or in the EACH community, where he or she might be a member of a larger multi-specialty clinic. I can also envision a group of physicians in the EACH community being the medical staff for a RPCH on a rotating basis.

RPCHs appear to fit in well with the trend toward outpatient delivery of health care. The physician who has surgical skills may still be able to do much of the surgery he or she always did.

The more formal network arrangement with a secondary care center may encourage surgeons in those facilities to utilize the RPCHs for outpatient clinics, surgery or procedures. The procedure-oriented physician will still have the hospital available for endoscopy, colposcopy, treadmill-stress testing, etc. And most patients would prefer to have their medical care provided locally. A well organized and functioning RPCH, with the administrative and technological support from an EACH, may be better able to provide those services than a struggling independent hospital.

Being "on call" for extended periods of time is certainly one of the most difficult problems with rural medical practice. Our family practice residents tell us that it is one of the major deterrents to entering solo practice or even small group practice in rural areas. EACH/RPCH doesn't completely solve this dilemma for the rural doctor, but it does offer several potential solutions. RPCHs are not required to maintain 24-hour emergency care on-site. They have the option of "checking out" the emergency care needs of the community to the EACH and the EMS system, which are integral parts of the EACH/RPCH network. It is also expected that much of the after-hours care at the RPCH may be provided by a physician extender on-site with telephone support from a doctor at the EACH. Neither arrangement may be as acceptable as having a 24-hour emergency room, but they are both much better than a hospital with a "CLOSED" sign on the door.

Rural, solo physicians feel a tremendous responsibility to keep the hospital open. When the hospital fails or has to levy more taxes to keep the doors open, many doctors may feel that they have somehow failed the people in their communities. These same doctors may already be tremendously burdened with the administrative load of being the only member of the medical staff. Networking with a larger, neighboring hospital that can help provide administrative support may make the day-to-day operation of a RPCH easier for everyone. The Kansas model has established a number of responsibilities for the hospital that will assume the role of an EACH. These should all encourage and support the physician who is willing to continue to serve the small rural Kansas community.

Unfortunately, one of the biggest issues for physicians when they consider such a transition is the one that our Technical Advisory Group has had the most difficulty in collecting data to support. That issue, of course, is physician income



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under such a system. Part of the problem our number crunchers have had is not knowing the rules that HCFA will use to reimburse physicians under an option called Integrated Part B Reimbursement. We have been told by our consultants that it will be significantly advantageous to a physician financially to be part of a system where a single payment is made to a hospital for both the technical and the professional component of care. But we do not yet have the data available to dispel physician skepticism about such a plan. I do know, however, that a number of Kansas physicians are reaping the benefits of the enhanced reimbursements of rural health clinic designation, and our consultants tell us that Integrated Part B will be even more favorable for doctors. We'll have to wait and see.

I don't present the EACH/RPCH concept as the answer to all that ails rural health care in Kansas, but I do see it as one part of the solution. It is not for everybody. But it would certainly appear to be right for some of our communities and some of our doctors. The decision to enter into an EACH/RPCH network needs to be by community-wide consensus. It probably won't work if the patient population is against it; it

won't work if the hospital board members don't understand it and are against it; and it surely won't work if the medical community is not supportive. The Kansas Hospital Association and the Kansas Medical Society stand ready to assist communities and physicians considering EACH/RPCH as a viable alternative in the community.

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Ventricular Tachycardia in a Newborn of a Mother with Scleroderma

CYNTHIA E. BATTISTE, M.D.,* AND MARK J. SPRINGER, M.D.,* *Wichita*

Ventricular tachycardia is rare in newborns.¹ The occurrence of pregnancy in systemic sclerosis (scleroderma) is also infrequent.² A case of ventricular tachycardia in a newborn of a mother with nonsystemic scleroderma is presented.

Case Report

A 2893-gm, full-term, white female was born to a 25-year-old gravida 3, para 2, abortions 0 female with nonsystemic scleroderma of ten years' duration on March 13, 1990. On January 21, 1990, maternal anticardiolipin IgM quantitative antibodies were 6.0 MPL units (mid-positive, 6–60 MPL), and IgG quantitative antibodies were 9.5 GPL units (normal <15 GPL). The pregnancy and delivery were otherwise uncomplicated.

The baby's physical examination was normal except for an irregular heartbeat. Electrocardiogram (ECG) showed premature ventricular contractions and ventricular couplets. Echocardiogram was normal. A 24-hour ambulatory ECG demonstrated premature ventricular contractions, ventricular couplets and ventricular tachycardia (Figure 1). Phenylketonuria, galactosemia and T4 newborn screens were normal. Hemoglobin was 18.0 gm/dl with a hematocrit of 53.0. Serum potassium was 5.6 meq/l, glucose 139 mg/dl, magnesium 1.6 mg/dl and ionized calcium was 4.4 mg/dl.

Propranolol 1.4 mg orally every 6 hours was ordered, but the patient actually received 2.8 mg every 6 hours due to a pharmacy error. A repeat 24-hour ambulatory ECG one day after starting propranolol did not demonstrate any ventricular ectopy. Blood pressure and glucose remained normal. The patient was discharged on a home apnea and heart-rate monitor.

She was admitted on April 3, 1990 because of

frequent monitor alarms. A repeat 24-hour ambulatory ECG at that time demonstrated sinus rhythm without ventricular ectopy. At seven and one-half months of age, she was readmitted for discontinuation of the propranolol under observation. Ventricular ectopy did not recur off the propranolol.

Discussion

Systemic sclerosis is uncommonly associated with pregnancy, perhaps because the highest incidence occurs in postmenopausal women. Fetal outcome has improved in recent years, but there is still an increased risk for premature birth and small full-term babies in women with systemic sclerosis (SSc).² A review of the literature did not reveal reports of pregnancy in mothers with nonsystemic scleroderma, as found in this case.

A relatively new postpartum syndrome associated with antiphospholipid antibodies (anticardiolipin and lupus anticoagulant), consisting of pleuropulmonary disease, fever and cardiac manifestations, has been described. Kochenour et al.³ reported one case with cardiomyopathy with extensive immunoglobulin deposition in the



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myocardium, and a second case with multifocal premature ventricular contractions. Antiphospholipid antibodies have been found in systemic lupus erythematosus (SLE) and in non-SLE disorders, such as rheumatoid arthritis and psoriatic arthritis.^{4,5} Anticardiolipin antibodies have been associated with recurrent fetal loss.⁵⁻⁷ In this case, the mother had mildly elevated anticardiolipin IgM antibodies but normal IgG antibodies.

Ventricular tachycardia has been reported in adults with localized and systemic scleroderma.⁸⁻¹⁰ Roberts et al. found ventricular tachycardia in 10% of 50 patients with progressive SSc on 24-hour ambulatory ECGs. Left anterior fascicular block, first-degree heart block, supraventricular tachycardia and ventricular couplets were also documented noninvasively in these patients. Functional abnormalities of the sinus node, atria, atrioventricular node, and His-Purkinje system were demonstrated by intracardiac electrophysiologic testing.¹⁰

Maternal SLE has been associated with congenital complete atrioventricular block.¹ Since antiphospholipid antibodies are frequently found in SLE (34% lupus anticoagulant, 44% anticardiolipin),⁴ there may be a correlation between the antibodies and conduction system disease, as well as recurrent fetal loss. We speculate that antiphospholipid antibodies could possibly cross the placenta and cause conduction system disease in the fetus in maternal scleroderma.

Conclusions

Both ventricular tachycardia in the newborn and pregnancy in scleroderma patients are rare occurrences. The two occurrences, in this case, may be coincidental. However, ventricular tachycardia has been reported in 10% of adults with scleroderma. Perhaps antiphospholipid antibodies transferred from a mother with scleroderma to the fetus could cause fetal and neonatal dysrhythmias.

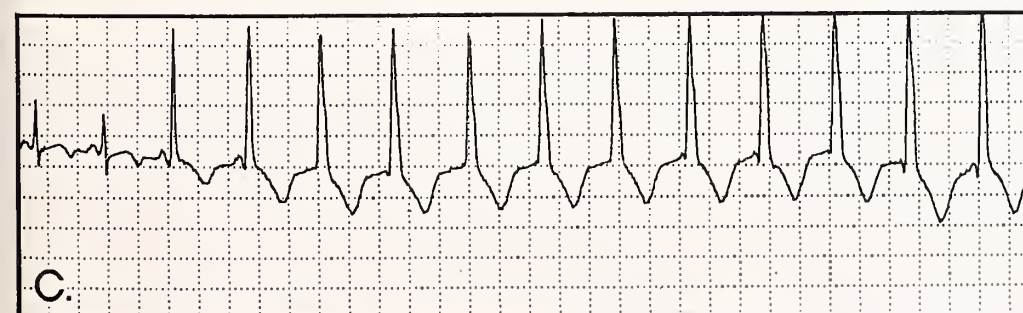
We conclude it would be worthwhile to check

for antiphospholipid antibodies in mothers with scleroderma and their newborns. We would also recommend monitoring such newborns, and perhaps fetuses, for dysrhythmias.

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Figure 1. A (left): premature ventricular contractions; B: ventricular couplets; C (below): ventricular tachycardia.



Physician to Rancher (and Back Again)

PART THREE

VICTOR J. VORHEES, M.D.,* *Fredonia*

In this section, which concludes Dr. Vorhees' account of his life among his cattle companions, he leaves no doubt about his dedication to them, particularly the maternal type, but this doesn't prevent him from missing his human patients.

These experiences are recorded to try to communicate something of the emotion which can be generated in caring for cattle. Not only is there an economic significance, but we also care deeply about these creatures who look to us to meet their needs. I doubt that many cowmen see them only in the economic light. There simply is not enough monetary reward for the work involved to keep one in the business if he does not love cattle.

The day following the euthanization of the calf mentioned in part two, we noticed a big bull calf, 48 hours old, lying where we had seen him the day before. This is unusual enough to get our attention, and we found his corneas steamy and the irises apparently adherent to them. When I tried to get him up, he went into an opisthotonic position and had what seemed to be a tonic seizure. The vet thought he had a possible poli-encephalomalacia related to a thiamine deficiency.

Some immediate improvement seemed to follow B vitamins given IV and IM, pilocarpine drops to the eyes and a dose of a new high-dollar aminoglycoside. But the following day he resumed seizure activity, became comatose and died about 60 hours after we first discovered him. Tetanus and intestinal infection were ruled out. Only a postmortem examination would show if there was an infectious disease in the herd, and streptococcal meningoencephalitis with cerebral edema was found. In retrospect, I realized aggressive antibiotic therapy might have been successful. But it would have been easy to invest more in the calf than he could have been sold for, a point of difference with human therapies.

One snowy winter morning, we saw a "short

yearling" heifer (just short of a year old) running in an arc. She crashed through a woven wire fence topped with barbed wire, broke off a steel post at the ground, bent two others and continued her circular course back to the same fence. She broke through it again and continued, bearing always to the right. She circled a small pond a few times before stopping. She looked alert and oriented without the drooping ears that often indicate illness. We concluded she was in heat, a situation in which the heifer is much harder to contain than a young bull.

Later, deciding we should check because of her bizarre behavior, we found her standing in the lot looking fairly normal. When we approached her, however, she resumed her circling to the right. We got her into the corral with its fence made of "sucker rod," which she could not go through. She appeared to see it but not perceive it correctly. Her circling now resembled a macabre pirouette.

The vet felt she had a central nervous system infection of some kind and treated her with antibiotics and dexamethasone. She seemed to improve slightly, lying with her head in a neutral position rather than drawn far to the right. Further treatment with DMSO led to her regaining her feet without resuming the circling. Even with continued aggressive treatment, however, she regressed and, when she began to convulse, we felt she had been put through enough and euthanized her.

We did not do a postmortem, but reference to my *Merck Veterinary Manual* produced a plausible diagnostic possibility: "circling disease," or listeriosis. Caused by *Listeria monocytogenes*, this process is ubiquitous; the organism has been isolated from 42 species of domestic and wild mammals and 22 species of birds, as well as fish, crustaceans, insects, sewage, water, silage, other

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feedstuffs and soil. Spontaneous recovery is infrequent and circling, though not constant, is always unidirectional.

The term “bonding,” in relation to mother and newborn, first came to my attention through Dr. Lynn Carmichael of Florida, who discussed it (using cattle as an example) at a Society of Teachers of Family Medicine meeting. I was skeptical, not having been aware of bonding in cattle myself. But I now realize the magnitude of my ignorance.

Bonding (in cattle, at least) seems normally to begin during labor. A cow going into labor is restless, often licking at her side and kicking at her belly with the first contractions. She will often leave the herd, going to as private a place as she can find. She usually smells the ground, apparently seeking the right place to calve (though I do not know her criteria). This will usually be in timber, if possible, but if she is penned in a lot, she will usually go to a far corner. Often, the same place will be used cow after cow, and we get used to looking in the “obstetric corner” of the lot when checking on pregnant cattle.

Before she has settled on a place, it is usually fairly easy to move the cow to another area for observation. But if disturbed after picking her spot, she will resist leaving the area and if forced may have a cessation of labor for a time. As the contractions increase in intensity and frequency, the cow may lie down but will rise frequently, turn around and inspect and smell the ground where she has been lying. When her water breaks, she will often drink or lick up the amniotic fluid. This appears to be important in identifying the calf when it is born — by either taste or smell.

On delivery of the calf, she will usually rise, turn and smell the calf and start licking it, beginning with the nose to clear it for breathing. She continues until the slippery, almost soapy, amniotic fluid is removed. This licking stimulates the calf to move, cough out fluid and shortly try to rise and suck. The cow usually proceeds to eat the membranes and placenta (a procedure common in the “natural childbirth” of animals but beyond the usual acceptance of human advocates of that process). The reason for this is obscure, but it possibly reduces the attraction of predators and scavengers to the area during the calf’s most helpless early life. It does not seem necessary for bonding.

But several things may go amiss at this point in the bonding process. Occasionally, two cows will calve at the same time in the same area. Rarely,

one will “claim” (bond with) the calf of the other cow and reject her own. I have wondered if the confused mother has smelled or tasted the amniotic fluid of the other and misbonded as a result. I do not know. One of our cows never seemed to raise a calf of her own, though she would usually have the calf of another cow nursing her. One day I came upon this cow from behind and spoke to her, but not until I touched her did she seem aware I was there. She appeared to be deaf, and I wondered if she might also have an olfactory deficit — and if these problems might explain her inability to identify and bond with her own calf successfully. (It also occurred to me that this may have been the reason the former owner sold her to me.)

If the mother is unable to carry out this ritual of smelling/tasting or licking (for example, delivery by pulling, especially if the cow is in a headgate, or by C-section), she may not bond readily with the calf. We have learned (the hard way) to take the calf to the mother’s head to permit her to perform these natural functions. Then, after we separate them for the ride home in the trailer (so she will not accidentally step on the calf), bonding is easier when we unload them at home. We are planning to build a small partition to go in the front of the trailer, which will permit a cow to put her head over. With this barrier, she can continue her mothering during the ride.

With a cow in the headgate, we have pushed the calf up to her to suck. Though she often kicks at it, she can learn by negative reinforcement not to do this. (I have hurt myself on occasion kicking her back!) Sometimes we will milk her out and bottle-feed the calf a few times, especially if the calf has become weak from not being allowed to suck. When a cow fails to bond with her calf, it is sometimes possible to persuade her to do so. I spent nearly half a day with one heifer hoping to get her to take her calf, but every time the calf tried to suck, she kicked it. Finally, tired and disgusted, I turned away and sat on the ground saying, “I guess we’ll just have to sell both of them at the sale.” After sitting there a time, I turned and looked at them. The calf was nursing, and the cow was standing quietly. Perhaps I was the problem.

Once the bond is established, it is ordinarily very strong. Trying to load an unwilling cow into a trailer in a pasture without a roping horse or fantastic stock dogs is an exercise in futility. But taking a newborn calf into the trailer in view of the mother will often prompt her to follow. In

fact, threatening this bond by molesting the calf can be hazardous. In the first 24 hours, we tattoo identifying numbers onto calves' ears and place a numbered tag in one ear. Bull calves not to be saved for breeding stock are also castrated. Such activities require catching and holding the calf, which often protests loudly at the restraint, though the procedures themselves seldom evoke much fuss or evidence of discomfort. Some cows are more protective than others, but we have a few whose calves we do not bother unless we can get the calf into a place where the mother cannot get to us. On occasion, I have gotten a fairly good butting in the process.

If the cow has bonded and the calf dies, she will usually stay by it and protect it for some time. One cold spring night, one of our cows delivered a dead calf unattended and, having bonded with it, stayed by it. At the same time, another cow delivered a big, healthy calf nearby but for some reason would have nothing to do with it. The strong, vigorous calf was trying to nurse every cow in the herd without success. Loading the dead calf into the trailer, we got the mother to follow us. In the corral, we tried to get her to take the living calf, but she refused.

We skinned the dead calf and laced the skin onto the live one. The cow immediately began to mother the calf and allowed it to suck. Though the skin was heavy for the calf, he managed well. But after 24 hours, the skin was developing odors unlike the original ones and we cut it off. The mother never seemed to notice; she continued to care for the calf (now known as "Little Two Skins") as though he were her own.

Another similarity I have observed between human and bovine obstetrics is the "cry of delivery." This, once heard by a physician or nurse, will always be recognizable. I cannot commit to paper how the cry sounds, but it means "I am delivering my child NOW!" Many times I have seen nurses and physicians jump and run when that cry was heard from a woman in labor. In my experience, it has always been followed by delivery very soon afterwards. There is a corresponding cry occasionally heard from cows. Though most cows make little, if any, sound in labor, many will, during the ultimate contraction, utter a bawl which is distinctive and significant of the same thing in women. A cow's silence during labor seems to me to have an obvious survival benefit, that is, avoiding signalling to any predators lurking nearby that an infant is about to be born. I must

"Another similarity I have observed between human and bovine obstetrics is the 'cry of delivery.'"

confess, however, that the "natural" or evolutionary significance of the cry of delivery escapes me.

Natural childbirth, mentioned earlier with regard to the eating of membranes and placenta, is, of course, the norm for cows. Those events are less well remembered and recounted than the "unnatural" events. "Natural" and "normal" are anything but synonymous, but it seems to me human patients often come to equate natural with free from harm. While I admit that there exists a significant level of meddlesome obstetrics in both human and veterinary medicine, Mother Nature certainly can bungle things herself.

This concept of "natural" not necessarily being beneficent was succinctly put by a young lady under my care. I feared for our relationship early on when she talked incessantly of what she wanted me to promise to do or not to do. I consistently vowed to do those things I thought best and safest for both mother and baby and pled with her not to tie my hands with any other promises. This uneasy state continued for several weeks until one day when she was discussing her desire for the birth to be a "natural event." Suddenly, she stopped her monologue, and a look of enlightenment came over her face. "I guess," she said rather slowly, "that a tornado is a natural event, isn't it?" There was no further conflict through her prenatal care or delivery, which were both normal and as natural as technologized and civilized medicine can provide.

A sign on the wall of the nurses' station at Wesley Medical Center said, "Normal delivery is a POSTPARTUM diagnosis." I understand that very well but am still not at all sure I know what really constitutes a "natural childbirth."

The gratitude of a human patient for whom you have worked is a wonderful reward. Not often have I perceived gratitude on the part of animals to whom I have ministered. However, one bitterly cold night with a frigid, piercing wind of 25 to 30 miles an hour, I listened to the wind howl

and could not forget a group of cows and calves in a pasture with no shelter but a low pond dam — which was lying in the wrong direction to give them protection. Telephoning my son, Rod, I found he was having the same insomniac experience. So we agreed to see what we could do.

We had some “carryover” Sudan grass no longer of high quality, as the big, round bales were left over from the year before. We took a bale to the animals huddled on the frozen ground and scattered the hay in a fluffy pile 18 to 24 inches deep. We couldn’t stay out of the tractor cab long because of the cold, but as we made their bed the cows began to cavort about, kicking up their heels and tossing the hay in the air. By the time we left, the cows and calves were snuggled into enough hay to be reasonably comfortable. I will always believe they were actually trying to communicate their gratitude, and the memory of those cows frisking in the hay warms me yet.

Though I care for cows beyond simply providing food and shelter, I became aware after four years away from medical practice that my identity was wrapped up in the interchange with human patients far more than I had believed. For about 18 months after leaving practice, I had been in administrative medicine. This offered some human interchange, but I missed seeing patients.

My “inactive” license, with its prohibition of practice, led to a feeling of professional impotence. I came to regard myself as a doctor, but not as a physician. I pondered ways of regaining my identity, including the possibility of covering local physicians’ offices on days they were off or vacationing. Lack of acquaintance with the local physicians and questions of compatibility deterred me until one day when I took my father-in-law to see a young female physician who was a graduate of the residency program with which I was once involved. I could see that there were several hours a week when the office, though open, was without a physician.

One day, the agony of passing a kidney stone led me to see this same young physician. During the recovery period, I wanted to bring up the subject of my assisting in the office but suffered the same inhibitions of an awkward, unattractive teenager approaching the popular cheerleader captain. Nevertheless, I decided to take the risk and found that she was not only receptive but indicated that she and her partners had been pursuing the idea already. (I was pleased with this providential turn of events but wished it could

have been brought about by some less painful means than a kidney stone.)

The result is that I practice in the office three half-days a week without hospital work, obstetrics or taking calls, and the plan has been in effect somewhat over a year. I have no intention of building a practice (though some patients have seen me primarily and look on me as “their” physician). I am still uncertain if I can “chip” at medical practice without becoming addicted, but so far things are going well.

I shall never forget the morning I received a call from the State Board of Healing Arts and a young lady said, “Your license is active again.” What a rush! I felt whole once more. I may not want to continue seeing patients forever, but I don’t, at present, contemplate quitting again. For the moment, I am mingling my ministrations, serving both people and cattle. I continue to see parallels between human and animal behavior, enjoy interaction with both and, in fact, feel I pretty much have it all.

Dr. Vorbees is now in family practice in Yates Center.

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Healthy Holidays

If you usually diet after the holidays, you're not alone. According to the Calorie Control Council, about 5 million other Americans do, too! But wouldn't it be great if you didn't have to go on a diet every January? Here are some suggestions for maintaining your weight year-round.

Avoiding a holiday weight gain involves maintaining your usual habits most of the time, or at least finding equivalents for those activities. Working exercise into your holiday schedule may seem impossible, but it can be quite easy if you make it part of your daily activities. For example, leave your car in a far corner of the mall parking lot and walk the rest of the way. Or if the weather is bad, park near the end of the mall *opposite* where you plan to shop, and walk through the mall to your destination. Once inside, use stairs instead of the elevator.

Of course, exercising is not the only way to avoid gaining unwanted pounds. Substituting beverages such as diet pop, club soda or vegetable cocktail for alcoholic drinks or eggnog at parties will save you hundreds of calories! Since the holiday season often includes lots of entertaining, try serving your family and guests foods that are elegant and special, but not high in fat or sugar. On the following pages are some recipes and tips designed to help you entertain in style and keep you in shape, too. Happy, healthy holidays from your doctor and the Kansas Medical Society!

Party Foods

PORK-APPLE BITES

Here's a delightful variation on the ever-popular meatball. And each one contains only 44 calories!

- 1 pound ground pork
- 1 teaspoon salt
- 1/4 teaspoon cinnamon
- 1/8 teaspoon pepper
- 1/2 cup shredded pared apple
- 1/4 cup soft rye bread crumbs
- 1/4 cup chopped walnuts
- 1/2 cup apple jelly

Sprinkle salt, cinnamon and pepper over pork;

add apples, bread crumbs and walnuts. Mix lightly but thoroughly. Shape mixture into 40 balls (1 scant tablespoon each). Brown balls (half at a time) in large frying pan. Pour off drippings. Add water, cover tightly and cook slowly 15 minutes. Remove balls to warm chafing dish. Stir apple jelly into cooking liquid and cook until melted. Pour sauce over meatballs.

Calories: 44 per meatball/protein 2 gm/fat 3 gm/cholesterol 8 mg/sodium 63 mg.

— From the Kansas Pork Producers Council.

BEEF AND TWO-PEPPER STEW

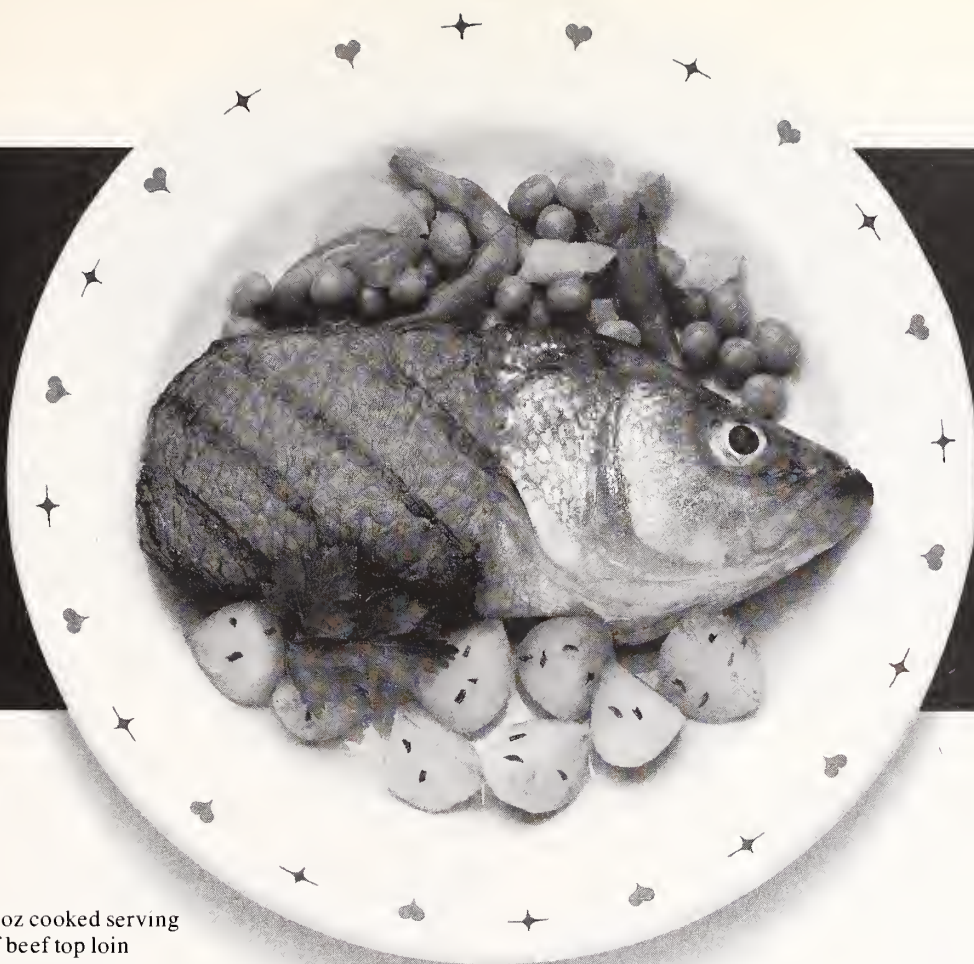
Having friends over to watch the New Year's Day parades and bowl games? Let this stew simmer while you enjoy the festivities. Then serve it with corn bread and a tossed salad.

- 1 1/4 pounds well-trimmed beef tip roast, cut into 1-inch pieces
- 1/2 cup coarsely chopped onion
- 1 large clove garlic, minced
- 1 tablespoon vegetable oil
- 1 1/2 teaspoons dried oregano leaves
- 1 teaspoon ground cumin
- 1/2 teaspoon each crushed red pepper pods and salt
- 4 medium tomatoes, chopped and divided
- 1/3 cup water
- 1 can (4 ounces) whole green chilies
- 1 tablespoon cornstarch
- 1/4 cup sliced green onion tops

Brown beef, onion and garlic in oil in Dutch oven. Pour off drippings. Combine oregano, cumin, red pepper and salt; sprinkle over beef. Add 3 cups tomatoes and water, stirring to combine; reserve remaining tomato. Cover tightly and simmer 1 hour 55 minutes or until beef is tender. Meanwhile drain green chilies; reserve liquid. Cut chilies into 1/2-inch pieces; add to beef mixture. Combine cornstarch and reserved liquid; gradually stir into stew and cook, uncovered, until thickened. Stir in reserved tomato; garnish with green onion tops. 4 servings.

(Continued on page 290.)

Let
our
patients
know
they
can eat
beef...



...as
well
as
fish.

3-oz cooked serving
of beef top loin

While fish and chicken are appropriate choices for fat-modified diets, so are lean cuts of today's beef.

The fat profile of lean beef may surprise you. And with beef's good taste and versatility, you can improve the chance of patient compliance with your dietary recommendations.

Today, beef cuts are lower in fat. According to a national supermarket survey, there is on average 27% less trimmable fat on retail beef today than in the late '70s and early '80s.¹ A follow-up survey in 1990 confirms a continued reduction in fat trim.²

AHA and NCEP guidelines allow lean beef

The American Heart Association and the National Cholesterol Education Program have recognized the place for lean beef in a varied, balanced diet. Both of their dietary guidelines recommend up to 6 oz daily of lean beef and meats, poultry, or seafood.^{3,4}

Here are guidelines that can help your patients enjoy beef that's compatible with a heart-healthy diet:

- Purchase lean cuts
- Keep portions moderate (3 oz cooked)
- Remove visible fat before cooking
- Prepare without additional fat

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Recommend
Today's Lean
Beef



A Heart-Healthy
Choice

KIBIC
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Per serving: calories 255/total fat 9.7 g/calories from fat 87/saturated fat 3.0 g/cholesterol 81 mg/sodium 523 mg.

— *From the Kansas Beef Council*

Elegant Entrées

These recipes are three-way winners. All are quick and easy to prepare, besides being low in calories and fat. Best of all, they look and taste wonderful.

PORK TENDERLOIN WITH RASPBERRY SAUCE SUPREME

- 1 pound pork tenderloin, cut into 8 crosswise pieces
- Cayenne pepper, to taste
- 2 tablespoons margarine
- 2 kiwi fruit, peeled, thinly sliced
- 6 tablespoons red raspberry preserves
- 2 tablespoons red wine vinegar
- 1 tablespoon reduced-calorie ketchup
- ½ teaspoon horseradish
- ½ teaspoon soy sauce
- 1 clove garlic, minced
- Fresh raspberries (optional)

Press each pork tenderloin slice to 1-inch thickness. Lightly sprinkle both sides of each slice with cayenne pepper. Heat margarine in large heavy skillet over medium-high heat. Add pork slices; cook 3-4 minutes on each side.

Meanwhile combine preserves, vinegar, ketchup, horseradish, soy sauce and garlic in small saucepan; simmer over low heat about 3 minutes, stirring occasionally. Keep warm.

Place cooked pork slices on warm serving plate. Spoon sauce over; top each pork slice with a kiwi slice. Garnish serving plate with remaining kiwi slices and fresh raspberries, if desired.

Serves four. Per serving: calories 300/protein 25 gm/fat 10 gm/cholesterol 79 mg/sodium 164 mg.

— *From the Kansas Pork Producers Council*

BROILED STEAKS WITH HERB-CHEESE POTATOES

- 4 frozen beef tenderloin or top loin petite steaks, cut 1 inch thick (about 4 ounces each)
- 2 baking potatoes, cut each into 6 lengthwise wedges

- 1 tablespoon olive oil
- 1 teaspoon dried basil leaves
- 1 tablespoon grated Parmesan cheese

Place frozen beef steaks on one side of rack in broiler pan; arrange potatoes on the other side. Combine oil, basil and ¼ teaspoon pepper. Brush potatoes with seasoned oil. Place pan under broiler so surface of meat is 5 to 6 inches from heat. Broil 17 to 22 minutes until steaks are rare (140°F) to medium (160°F) and potatoes are tender, turning steaks once. Remove steaks and potatoes to warm platter. Sprinkle cheese over potatoes. Season with salt, if desired. Yield: 4 servings.

Per serving, made with tenderloin: 325 calories/12 g fat/5.4 mg iron/88 mg sodium/72 mg cholesterol.

— *From the Kansas Beef Council*

BEEF & FRUIT SALAD WITH TANGY POPPY SEED DRESSING

- 12 ounces cooked beef, cut into thin strips
- 1 carton (8 ounces) low-fat plain yogurt
- 1 tablespoon fresh lemon juice
- 1 tablespoon honey
- 1½ teaspoons poppy seeds
- Boston or Bibb lettuce
- 1½ cups cantaloupe balls
- 16 pieces (1¼ × 1 inch) fresh pineapple
- 4 (2-inch) wedges honeydew melon
- 1 cup seedless red grapes, halved

To prepare dressing, combine yogurt, lemon juice, honey and poppy seeds in small bowl; cover tightly and refrigerate while assembling salad. Line serving platter with lettuce; arrange cantaloupe, pineapple, honeydew and grapes on lettuce around outer edge of platter. Place beef in center. Serve dressing with salad. 4 servings.

Per serving: calories 378/protein 31 g/fat 11 g/cholesterol 80 mg/sodium 120 mg.

— *From the Kansas Beef Council*

Side Dishes

LOWER-FAT TURKEY GRAVY

- 1½ pounds turkey parts (necks and wings)
- 2 cups water

1 medium-size onion
 a few celery leaves
 ½ teaspoon salt
 ¼ teaspoon dried thyme leaves
 ½ cup turkey pan drippings
 3 tablespoons all-purpose flour
 3 tablespoons water
 salt and pepper

Put first six ingredients in a 2-quart saucepan. Bring to a boil and skim off foam. Cover, reduce heat and simmer about 1½ hours until meat is very tender. Strain and reserve broth. Save meat for another use. Chill and skim fat off broth.

Reserve about ½ cup of pan drippings from your roast turkey, and pour into a small saucepan. Place in freezer for about 10 minutes, just until the fat congeals. Spoon off and discard the fat. To the remaining drippings, add 1½ cups of the defatted turkey broth, and bring to a boil over medium-high heat. Meanwhile, mix the flour and remaining water in a small bowl until smooth. Whisk the mixture into the boiling broth mixture. Boil, stirring constantly, 3 to 5 minutes, until smooth and thickened. Season to taste with salt and pepper.

Makes about 2 cups.

GREEN BEANS WITH RED BELL PEPPERS

A festive dish with a red-and-green holiday color scheme.

1 tablespoon Mazola corn oil
 1 large red pepper, cut in thin strips
 1 large onion, thinly sliced
 1 pound green beans, cooked tender-crisp and drained
 2 tablespoons cider vinegar
 ⅛ teaspoon crushed dried red pepper (optional)

In medium skillet heat corn oil over medium-high heat. Add red pepper strips and onion. Saute 3 to 4 minutes or until tender. Add beans; heat through. Toss with vinegar and dried red pepper. Makes 4 servings.

Per serving: Calories 90/carbohydrate 12 g/polyunsaturated fat 2 g/saturated fat 1 g/cholesterol 0 mg/sodium 10 mg.

— From Mazola

A Sweet Treat

Let's face it: cheesecake will never be diet food. But if you're going to have a slice, wouldn't you rather have one with 100 fewer calories than traditional cheesecake? Oh, yes — it also happens to be delicious!

LIGHT 'N' LUSCIOUS CHEESECAKE

¾ cup graham cracker crumbs
 2 tbsp Mazola margarine, melted
 1 cup lowfat cottage cheese
 1 container (8 oz) lowfat plain yogurt
 1 package (8 oz) light cream cheese
 ½ cup sugar
 2 tsp grated orange peel
 2 tsp vanilla
 2 egg whites

In small bowl combine graham cracker crumbs and margarine. Pat into bottom of 8-inch springform pan. Bake in 350°F oven 10 minutes. Place cottage cheese in blender container; cover. Blend on high speed 2 minutes or until smooth. Add yogurt, cream cheese, sugar, orange peel and vanilla; blend until smooth. Add egg whites; blend until well mixed. Pour into prepared pan. Bake in 325°F oven 30 minutes. Turn off oven. Leave cheesecake in oven with door ajar 30 minutes. Cool on wire rack. Refrigerate several hours or until thoroughly chilled. Before serving, remove side of pan. If desired, serve with orange slices. Makes 10 servings.

Per serving: Calories 180/carbohydrate 18g/polyunsaturated fat 1 g/saturated fat 4 g/cholesterol 20 mg/sodium 270 mg.

— From Mazola

HAPPY HOLIDAYS

from

Your Physician and

the

Kansas Medical Society

THE WAY IT WAS

At the risk of fanning the flames of the sexual harassment wildfire, we cannot resist bringing to light the following essay from the March 1916 issue of the Journal of the Kansas Medical Society. (The Editor requests readers be advised that he has assigned responsibility for the reprinting of this column to the female members of the editorial staff!)

VEST POCKET ESSAYS

The Breast

The breast is a portion of the bodily structure of different significance according to which the term is applied and according to the person — physician, poet, lover, child — by whom the term is used.

Most generally the word carries with it the thought of woman. Indeed, the breast is the very symbol and badge of femininity. Song and romance dwell feelingly on the female bosom, and associate the most tender sentiment and inspira-

tion with its rhythmic movements. Artists of brush and chisel give stress to this important feature in all their delineations of heroine and madonna.

The masculine figure is portrayed in its majesty of bone and brawn, but woman is ever pictured and idealized in those curves that suggest and symbolize maternity. And enduring art is here, as always, consistent with life and experience. For the bosom of woman is the evidence of her more forceful charms. Here Nature, with the masterful strokes of a divine artist, builds those sweet convexities which rise and fall with every soft breath of her gentle life, and which so strongly appeal to the eye of her restless mate.

Here lie those succulent fountains to which, under the stress of primal necessity, the infant diligently applies himself. He not only assuages his hunger, but also pillows his weary head, quiets his petty griefs and takes refuge against the same soft hemispheres.

The virgin modestly and artfully conceals the alluring rotundities of her figure, but the matron proudly uncovers to her voracious offspring the tender fountains of its waxing strength. And the mother of strong men, grown weary of the burdens of life, fondly presses them to her withered bosom whenever, as of old, they return to her embrace.

Thus may we truly say that the breast of a woman is the seat and source of man's emotions and the sanctuary of his tribulations. What mysteries of life and development lie at these portals! What potencies for good and evil flow through these channels! O, you men of the flat and barren bosom! O, you fathers of the whiskered face and chest! You may breed into your progeny some of your masculine instinct by the single impress of your passion. But the maternal bosom will be potent to instill, day after day, the immortal and controlling impressions. Thus may we well believe that from the father come the transient and from the mother the permanent and superior attributes of the soul.

PRESIDENT'S MESSAGE

(Continued from page 272.)

It is unfortunate that, rather than trying to change individual physician behavior through education in cost-effective health care and practice parameters, Medicare seems to have reverted to the ancient behavior modification tool of restricting group privileges when individuals behave in a seemingly irresponsible fashion.

Larry Anderson MD

Early in November, Joe Leiker, M.D., J.D., Medicare Medical Director, notified the KMS office that for the time being, Medicare will continue to reimburse for organ-specific panels other than 80050, 80052 and 80053. Efforts of the KMS Third-Party Payor Committee and Carolyn Counts, Director of Health Care Finance, were instrumental in this Medicare decision. However, due to Medicare concern about what is viewed as widespread abuse of in-office organ-specific panels, specific directives will be forthcoming to identify procedures which constitute each organ panel, and reimbursement will be reduced to the sum of the payment for individual procedures. Those which are listed as "automated" will be paid in that fashion.

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Managing Survivors of Ventricular Fibrillation

DONALD L. VINE, M.D.,* *Wichita*

Occasionally, primary care physicians will encounter a patient who survives out-of-hospital ventricular fibrillation that is not associated with a Q-wave myocardial infarction.

Such patients may have a one-year risk as great as 20% for recurrent ventricular fibrillation, especially if they have risk factors associated with recurrence. Risk factors include advanced age, male sex, left ventricular dysfunction, a history of congestive failure or prior myocardial infarction, high-grade ventricular ectopy on Holter monitoring or inducibility at electrophysiologic testing.

The CASCADE Study

In Seattle, 50 to 100 of the 200 to 300 annual victims of cardiac arrest survive to hospital discharge. If neurologic recovery occurs within six months, survivors are evaluated for randomization to empiric amiodarone versus electrophysiology-guided antiarrhythmic drug therapy.¹

Patients are selected if they have documented ventricular fibrillation (not ventricular tachycardia with syncope), no associated Q-wave infarction, one or more risk factors for recurrence, and either electrophysiologic inducibility or complex arrhythmias on Holter monitoring.

The primary end point of the study is cardiac death or documented out-of-hospital ventricular fibrillation with successful resuscitation.

Preliminary Findings

At the time of preliminary reporting, 199 patients had been randomized. Of the patients randomized to the conventional electrophysiology-guided arm, approximately one-third were receiving quinidine and 20% procainamide. Twenty percent were receiving combinations of agents, and three had crossed over to amiodarone.

The most striking early finding was the initial mortality (Figure 1). Cardiac death was 19% at

TABLE 1
RISK FACTORS FOR RECURRENCE OF
VENTRICULAR FIBRILLATION

- No acute Q-wave infarction
- Male
- Elderly
- Previous CHF or MI
- Left ventricular dysfunction
- Complex arrhythmias at rest
- Electrophysiologic inducibility

the end of the first year. This increased to 29% at the end of two and 44% at the end of three years.

Since the study continues, it must be assumed that the high mortality observed for the group as a whole also applies to both the amiodarone and conventionally treated subsets.

Protocol Modification

The automatic implantable cardioverter/defibrillator was experimental at the beginning of the CASCADE study, and less than half of the patients had been treated with this device. In view of the high mortality associated with both forms of drug therapy in this trial, the investigators decided to implant defibrillators in all study patients, when clinically feasible.

Comments

It is risky to generalize from a limited clinical trial,

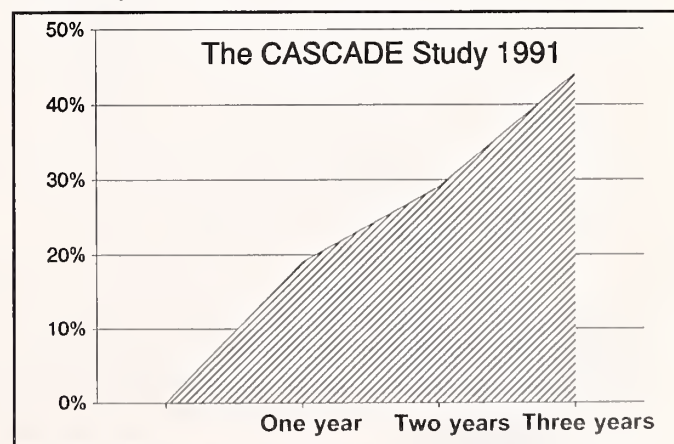


Figure 1. Recurrent cardiac arrest or death.

*Associate Professor, Department of Medicine, University of Kansas School of Medicine-Wichita

Address correspondence to Dr. Vine, Department of Medicine, UKSM-W, 1010 N. Kansas, Wichita, KS 67214.

Information for Authors

Manuscripts must be typewritten, double-spaced, leaving wide margins. The original plus one copy should be submitted. Manuscripts are received with the explicit understanding that they are not simultaneously under consideration by any other publication. Publication elsewhere may be subsequently authorized at the discretion of the editor.

Brief, concise **articles** are preferred; an ideal manuscript will not exceed five double-spaced pages. All material will be edited by the editorial staff to assure clarity, good grammar and appropriate language, and to conform to KANSAS MEDICINE style and format. When feasible, material may be condensed.

The author will be asked to review the **galley proof** prior to publication. Although editing and proofreading will be done with care, the author is responsible for accuracy of material published. The galley proof is for correction of **ERRORS**; rewriting of material *must* be done prior to submission. Authors are urged to check manuscripts and galley proof carefully for errors that could result in inaccurate information.

Drugs should be referred to by generic names; trade names may follow in parentheses if useful. All **units of measure** must be given in the metric system.

KANSAS MEDICINE will print a maximum of **ten references**. All references should be keyed with superscripts in the text in the order cited. If more than ten sources are cited, readers will be referred to the author for the complete list.

Illustrative material must be identified by its referral number in the text and be accompanied by a short legend. **Photos** should be black-and-white glossy prints. **Tables** should be self-explanatory and should supplement, not duplicate, the text.

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A **reprint** order form with a table showing estimated cost will be sent with the galley proof. Reprints must be ordered by the author through KANSAS MEDICINE, and will be billed to the author following shipment.

but the Seattle academic community has a great deal of experience with out-of-hospital cardiac arrest. What began as a randomized trial of two forms of drug therapy became a natural history study of drug therapy for a subset of cardiac arrest patients. The mortality exceeded that reported for similar patients treated with implantable defibrillators at other institutions, and the protocol was modified accordingly.

Presently, the occurrence of cardiac arrest associated with ventricular tachycardia or ventricular fibrillation in the absence of acute myocardial infarction is usually an indication for additional workup including electrophysiologic evaluation.

REFERENCE

1. CASCADE investigators. Cardiac arrest in Seattle: conventional versus amiodarone drug evaluation (the CASCADE Study). *Am J Cardiol* 1991;67:578-84.

EDITORIAL COMMENT

(Continued from page 270.)

The Betterment of Humanity can be done with a comfortable return. Those in residencies can take it as confirmation that they are on the right track. Those in actual practice will probably be too busy to pay much attention.

We promised not to bring in the oldsters — but who believed *that*? We “senior” physicians can look at such results and gaze upon our progeny with a mixture of awe and envy.

CORRECTION

It has been suggested that if one does not call attention to one's errors, they may not be noticed. Nevertheless, we cite the first paragraph of the “Editorial Comment” for September 1991, in which it is stated, “the infant mortality rate in this country ranks low. . . .” The fact is, of course, that it is the opposite, ranking high among the industrialized nations. We regret the error and the fact that the Editor has no one but himself to blame. D.E.G.

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Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecostasia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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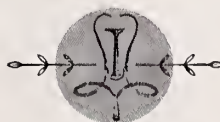
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Season's Greetings from the Kansas Medical Society



KANSAS MEDICINE

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**ABOUT OUR LOGO**

In January 1935, a new logo appeared on the cover of KANSAS MEDICINE for the first time. This device represents two stethoscopes: the original monaural type as used by Laënnec, and the modern binaural variety. The logo was designed expressly for KANSAS MEDICINE by renowned graphic designer Bradbury Thompson, a native of Topeka and friend of two former editors of the journal, Dr. W.M. Mills and Dr. Lucien Pyle. As another former editor, Dr. Orville R. Clark, wrote in January 1955, the logo "has become as much a part of the journal as any of the features on the inside and is something which is ours alone."

The first Christmas card (the first documented one, at any rate) was produced in London in 1843. The card market not being quite what Hallmark caters to today, only 1,000 copies were lithographed — but then, of course, each one had to be hand-colored. The subject was a festive group of diners gathered about a table and looking directly out at the viewer of the card. These happy revelers hold their glasses high for a toast, and the accompanying caption reads: "A MERRY CHRISTMAS AND A HAPPY NEW YEAR TO YOU." Ironically, this warm and cheery greeting was criticized for its "dissipating influence by 'encouraging drunkenness.'" (*The History of the Christmas Card*, by George Buday, London, 1954.)

Fortunately, there is nothing controversial about the exuberant scene in the Christmas card on our cover, which was created by Prairie Village artist Jim Hamil. The children depicted here are enjoying their Christmas holiday to the fullest. Most have sleds, some of which were probably left under the Christmas tree by Santa Claus only a day or two earlier. A well-timed winter storm has left a sparkling blanket of snow on which to test the mettle of the new toys. Someone's dog is having a good time, too, chasing the sleds down the snowy hill at full tilt.

Of course, a Christmas card is composed of two elements: the illustration and the greeting. And for a greeting suitable for this scene of frolicking children, it seems fitting to quote Kenneth Grahame, who captured the pleasures of winter for children (and their parents) in *Wind in the Willows*:

Villagers all, this frosty tide,
 Let your doors swing open wide,
 Though wind may follow, and snow beside,
 Yet draw us in by your fire to bide;
 Joy shall be yours in the morning!

Here we stand in the cold and the sleet,
 Blowing fingers and stamping feet,
 Come from far away you to greet —
 You by the fire and we in the street —
 Bidding you joy in the morning!

We trust that joy shall be yours morning, noon and night this holiday season and throughout the coming year.

School of the State

This issue carries a condensed version of Dean James Prices's "State of the Medical School" address to the faculty in Kansas City. (See page 306.) This gives us the opportunity to look over Dr. Price's shoulder and get a Dean's-eye view of that institution. His concerns are, not unexpectedly, financial, academic and political — with a dollop of moral support for his faculty charges.



The points he raises should be of interest (and concern) to all Kansas physicians. (After all, the Kansas Medical Society was a prime mover in the establishment of that institution a century ago, and events in Kansas City or Wichita continue to be of significance to every level of medical practice in Kansas.) The health of these institutions is reflected in the level of medical care in the state, especially in these days when medical practice is under increasing scrutiny by the jaundiced eye of the public. Physicians are being forced to devise means of meeting public criticism while at the same time trying to produce solutions of their own. The branches of the medical school comprise an important focus for exhibiting to the Kansas public the value of its medical service.

But the common denominator of the matter is that ubiquitous intruder: money. This brings us to the approach of that annual season of political strife as the Legislature convenes to figure out how to balance state income and outgo. Concerns about this process are reflected in Dean Price's remarks since, as with those in charge of any state institution, he will have to strive to demonstrate that his charges are worthy of the school's requests. That this has been a problem in the past and will be again is a foregone conclusion. It is apparent that many — probably most — legislators recognize the value of maintaining our medical centers in a healthy state, but that interest will still be translated into dollars when the pot is divided.

One item that caught our eye was Dr. Price's report of a suggestion that it might be cheaper to subsidize Kansas students to go elsewhere to medical school rather than maintain these plants. We hope the idea was advanced as irony but, given some of the utterances of legislators, one can't be

sure. We doubt the idea will gain much credence, but it stimulated us to do a little checking on our membership.

According to the KMS 1991 directory, a shade over half of the physicians practicing in Kansas (and members of the KMS) are graduates of the two branches of our school. It strikes us that this is a fairly healthy condition. First, it indicates a satisfactory retention rate of our graduates — perhaps more than satisfactory, but we admit we don't know how other states compare. This doesn't leave much question as to the value of the maintenance of these institutions. Moreover, a significant proportion of these physicians are practicing in the smaller communities. Dr. Price cites the problem of justifying the expense of the school when so many counties are classified as medically shortchanged. We suggest that this is as much a demographic problem as a medical one. Kansas medicine has already been active in devising methods of resolving this inevitable result of a social dilemma which permeates every form of social service.

But this 50/50 condition of practitioner sources has other interpretations. First, it means that the remainder of our members have gone to other areas. And those who are Kansas natives are ambassadors of Kansas medical education. Their presence in other communities speaks well for their preparation, and the cost of their education in Kansas can hardly be counted a total loss. Their counterparts, of course, are those who are bringing their training and practice expertise to Kansas from other sources. It is the nature of medicine that the exchange, the mingling of medical thinking and performance, is a healthy thing which has been attested to throughout world history.

Perhaps even this much attention gives unnecessary credence to this thought of sending our students away to school en masse, but it also suggests another probable result: the loss of Kansas physicians would inevitably be significant, since far more than half of Kansas students would likely fail to return.

If the school adds up to a plus for Kansas medicine, it (the inclusive "it," since both branches are involved) obviously warrants the support of all physicians in Kansas, and we would be well advised to give firm support to its efforts. D.E.G.



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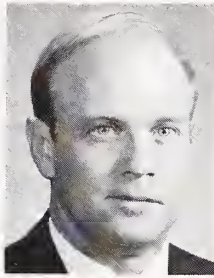
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Enough Is Enough

On October 16, 1991, representatives of the Kansas Medical Society and the Kansas Hospital Association met to discuss the issue of capital expenditure for new diagnostic and health care equipment and facilities (Certificate of Need). Current legislative discussion in Topeka has considered a moratorium on new construction for Kansas acute care facilities, and this KMS/KHA meeting was held to consider a joint statement to address this issue. The majority of those present at this meeting spoke against a moratorium but in favor of a comprehensive study of Kansas health care needs. Discussion substantiated the fact that earlier Kansas Certificate of Need legislation failed to truly assess community health needs, to stop any proposed construction (some of which may, in retrospect, have been unnecessary) and to consider regional and state health care needs. It also increased the total cost through bureaucratic expense and increased construction cost associated with delayed approval.



Within the last few weeks, this KMS/KHA statement has been delivered to the Joint Committee on Health Care Decisions for the 1990s. There appears to be good legislative support to work with the recently established Commission for the Future of Health Care, Inc. to accept the KMS/KHA recommendation to try to identify available funds for a comprehensive study of Kansas needs, rather than to enact legislation calling for an immediate moratorium on construction of new acute-care facilities.

It is well known that physician incomes are a small percentage of the total health care dollar, but physicians control in some way or another most of the dollars spent for health care. A quick look at many Kansas communities will show that large health care expenditures are often utilized, not necessarily for truly needed medical care but rather where a market for a medical service has been generated.

A study of Arizona physicians published in the December 6, 1990 *New England Journal of Medicine* reports that physicians with in-house x-ray equipment order four times more radiographic studies on identical patient populations than do specialty colleagues without in-house radio-

graphic capability. An article in the September 30 *Physician Financial News* stated that Florida physicians who own laboratory facilities order twice as many lab studies at twice the cost as do physicians without laboratory ownership. These statements are not to imply that all ownership of diagnostic or treatment facilities is bad. However, I think most would agree that the entrepreneurial nature of our current health care system allows and, in fact, encourages overconstruction and overutilization even though excellent care can often be provided with less diagnostic and therapeutic intervention.

“Excellent care can often be provided with less diagnostic and therapeutic intervention.”

At the KMS/KHA meeting previously mentioned, it seemed to be generally agreed that, although Kansas citizens currently suffer from a lack of access to primary care physicians, they do not suffer from a lack of diagnostic or therapeutic equipment that could reasonably be more available than at the present time. Arnold Collins wrote in the October 7 *American Medical News* that the American health care system has been losing primary care physicians for the last several decades and has gotten to the point where “the sideshow is swallowing up the main tent.” Kansas does not need more acute care facilities, cardiac cath labs, MRIs, Level III nurseries or rehab hospitals! What Kansas needs is more primary care physicians!

Many hospital administrators and physician leaders argue for a “voluntary community effort” to control overbuilding of health care facilities. I say voluntary effort is a joke unless a majority of physicians stand up in their hospital and physician group meetings to speak against new construction when this construction is plainly to enhance the image of the institution, provide a financial advantage or develop a demand where a need truly does not exist.

Larry Anderson, M.D.

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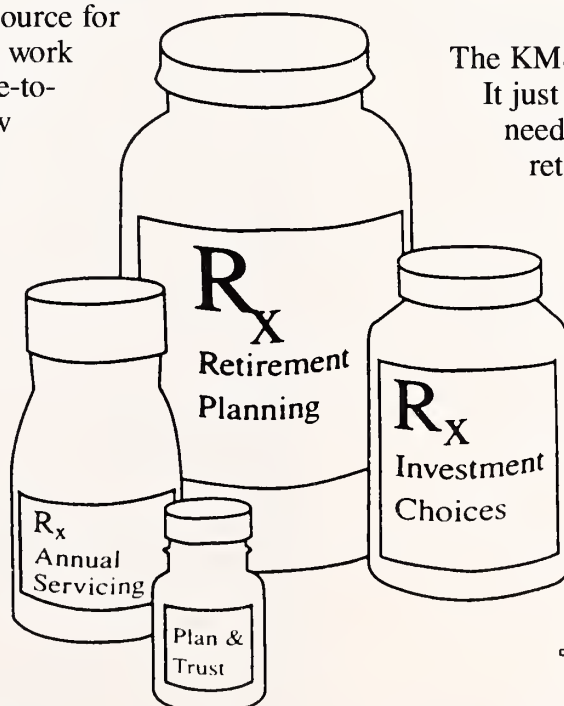
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Peer Review: A Risk Re-Analysis

WAYNE T. STRATTON, J.D.,* *Topeka*

Last month's column dealt with the recent developments in the law pertaining to liability for performing peer review. No other aspect of health care obligates a physician to give so generously of his or her time and knowledge for the benefit of society, participating in decisions which affect the future of a colleague, with the fear of litigation constantly present. As a practical matter, how realistic is the fear?



The answer depends upon the perspective of the observer. It is difficult to reassure someone who has a morbid fear of flying with a recitation of the statistics of its safety. The fact that few challenges to peer review have ever resulted in individual liability for a physician is not totally reassuring, when the consequences can conceivably be so devastating, and the process so vexing.

But what is conceivable or remotely possible should not be the criterion; in the modern era, nothing is free of risk. While the suggestions of the AMA mentioned in last month's column will serve to insulate physician reviewers beyond the protective features found in today's laws, if and when they may be adopted is unknown. Present state and federal law offer an abundance of protection if certain fundamentals are followed:

1 The peer review action must be taken in the reasonable belief that it is in furtherance of quality health care. This requirement should be self-explanatory. Physicians should avoid involvement in any proceeding which appears to be motivated by vengeance or for anticompetitive purposes.

2 The procedure should follow and be author-

Am I likely to be sued?

ized by written bylaws and policies. Staff members should ensure that any institution which performs peer review has adopted the necessary procedures required to comply with the Health Care Quality Improvement Act of 1986 and with Kansas law.

3 Avoid involvement in any matter in which the reviewer will or could obtain a competitive advantage from the action. Alternative mechanisms are normally available to allow physicians to avoid those situations.

4 Members of the committee should be familiar with the procedures and not only follow them, but require others to do so.

5 Whatever time is necessary to learn the facts of the matter must be taken. A committee member must satisfy himself or herself that the facts are understood, and rely upon others to perform what really is an individual responsibility.

6 The decision which is reached is arrived at in the reasonable belief that such action is warranted by the facts then known. In other words, the conclusion should result from the natural application of the reviewer's knowledge and experience to the factual situation.

7 See that the required reporting is accomplished. The protection afforded by the HCQIA may be lost if this is not accomplished.

No one should be exposed to liability if the foregoing principles are followed.

*KMS Legal Counsel.

Comments appearing herein are not intended as a substitute for legal analysis or advice. Answers to legal questions depend largely upon the particular facts of a case. The reader is urged to consult an attorney for answers to specific legal questions.

These comments do not necessarily represent the views of KANSAS MEDICINE, or the Kansas Medical Society. For further information, contact Mr. Stratton, 515 S. Kansas, Topeka, KS 66603, 1-800-332-0248.

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Joy Bell Reaches Out for Others

This year's KMS Auxiliary President — its 67th — is Joy Bell, of Salina. Moving into this position was not something she had expected until last spring, when unforeseen circumstances in the families of Lisa Barker and Terrie Browning led to her election. "It's a lot of work," said Mrs. Bell, "but the enthusiasm and energy of the state officers, chairmen and county presidents were overwhelming and have made a difficult job both easy and fun."



The theme Mrs. Bell selected for her year as president is "Reaching Out for Others," and the auxiliary's projects have focused on the importance of helping others. "When we reach out to our communities, it is a positive message that we, as physicians' families, care," she explains.

In her own community, Mrs. Bell serves as a board member of Salina United Way, volunteers at St. Mary's School and is a member of the Asbury-Salina Regional Medical Center and St. John's Hospital auxiliaries. She has also served as a volunteer for the Smoky Hill River Festival for the past five years.

Until her election, Mrs. Bell was working at an interior design firm in Salina. She had also been active in the KMSA and Saline County Medical Auxiliary for several years, serving as Saline County President in 1987-88 and again in 1990-91, KMSA Yearbook Chairman in 1988-89, AMA-ERF Chairperson in 1989-90 and KMSA Secretary just prior to her election as president last spring. For the past five years, she has been either a delegate or an alternate delegate to the AMAA national convention, and she has the stickers to prove it! (See the article below.)

Joy and her husband, Mark, an otorhinolaryngologist, have lived in Salina about eight years. They have two daughters, Tamera (10) and Tia (8), and Mark's daughter Tara, from a previous marriage, is a frequent visitor to their home.

A Sunflower Blooms

It is recess time on the floor of the AMAA Annual Convention in Chicago. The aisles are over-

flowing with tight-knit groups that bottleneck movement in all directions.

An outsider might ponder the hive-like activity, concluding that some powerful piece of business has come to the attention of the delegates, causing a flurry of last-minute caucuses. The outsider would be wrong.

It is the time-honored auxilian tradition of "sticker trading." With the fervor of Wall Street brokers, the delegates attempt to leave Chicago with a complete collection that includes at least one sticker from every state.

Don't go to Chicago unprepared! New Mexico, Nevada, New York and Puerto Rico are among the delegates with no sticker currency. Phone calls are placed. On the second day, fat express-mail envelopes arrive with apple pins, flowers and dominos. On the third day, Puerto Rico's stickers finally arrive, along with small bottles of rum.

While some states suffer from "sticker deprivation," others enjoy multiple blessings. Kansas brings sunflowers and wheat. It quickly becomes apparent that the seasoned collector is after the sunflower. A few delegates are privileged to get a Liberty Bell from Pennsylvania, while the masses get PMSA pins. Floridians pass out oranges, but word-of-mouth reveals the existence of a rare "gator-doc" pin, if you can find a source.

By the final day we are plastered, pinned and buttoned with a plethora of souvenirs. It is only on the plane headed back to Kansas that we wonder what in the world we'll do with them when we get home. Was it a frivolous way to spend our time?

But what may appear frivolous is the most important function that any organization may serve. It serves *people*, and any value it has is in its *people*. Every time a sticker is traded, two people "connect." What they take away is of much greater value than the sticker that has passed hands. A woman from Kansas learns that her frustrations, her hopes and her joys are shared by another woman in Georgia. We, the people, *are* the organization. No matter how convoluted the structure, no matter how intricate the rules, no matter how divisive the issues, we are connected and of one purpose. Being a medical spouse, especially today, is a difficult, demanding, lonely profession. It's nice to know that in that vast expanse called "somewhere out there," a Kansas sunflower blooms . . . even if it *is* a sticker.

*Ann Huseman
Public Relations Chairman*

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The State of the Medical School

JAMES G. PRICE, M.D., *Dean*

As I report on the state of the Kansas University School of Medicine, which we hold in trust for the people of Kansas, we must never forget that we have a definite responsibility to our "landlords." This responsibility dictates that we assist them both in the formulation of their expectations of this institution and in the meeting of these expectations.

I do want to thank you all for being patient, helpful and understanding during these last 19 months as I've been learning the ins and outs of the job — and please don't stop quite yet.

Overall, the school is in reasonably good health. Like our patients, there are areas in need of immediate attention, and our condition can be seen as good or not so good depending upon our attitude. Is our glass half full or half empty? Our determination of how good or bad off we think we are will determine how effective our approaches to improvements are likely to be.

In the Dean's Office, some changes in structure and personnel have been made. The appointment of Associate Deans to manage specific areas of service should expedite the function of the office. During the next year, if financial and other arrangements can be made, I would like to fill out that cadre with an Associate Dean for Research. All are there to assist you in your work.

In regard to students, we are, so far this year, 21% ahead in the number of applicants as compared with last year. However, the number of Kansans applying is exactly the same as last year at this time. Over the last four years, the MCATs of enrolled students climbed from a mean of 9.03 to 9.34 (statistically significant), while the GPAs of enrolled students fell from a mean of 3.5 to 3.48 (not statistically significant) during the same period. Thus, the academic quality of the pool is remaining stable as the size of the pool sharply increases. Even as the pool size has increased, every academically qualified Kansan was sent an acceptance last year, and we still had room for about 35 out-of-staters.

As you know, we underwent an LCME accreditation site visit a year ago. Our maintenance of two campuses makes our situation somewhat

more precarious than that of most schools. Nevertheless, we did get fully accredited, with a list of concerns being cited. A return limited site visit is scheduled for the fall of 1992. This will determine how well we have addressed the LCME concerns and could result in some kind of accreditation problems if we fail to satisfy their expectations. Within the next two weeks, this faculty will be assembling a steering committee to review the LCME matters, review our progress and guide efforts toward compliance. I am quite confident that we will come through this next visit with flying colors.

Faculty governance has been a topic of concern. A huge effort has been made to create a setting where faculty input to important issues will occur. A committee to rewrite our faculty bylaws has been working for almost a year, and an all-but-finished draft of the document will be mailed to every faculty member. This will be followed by a series of open meetings to give the faculty the opportunity to express opinions and suggest changes. Members of the bylaws or governance committee will be available so the thought processes behind the effort can be given.

I believe our curriculum to be out of date and in need of major revision. If we don't decide to modernize it, particularly in response to governmental needs, others may do it for us. With computerization, we can easily tell who teaches what to whom and when it is done. The state Legislature is already asking us about our efforts in teaching primary care. In fact, I was asked recently whether or not we had ambulatory patient teaching in the third year of medical school. That's the level of sophistication and curiosity of our legislators. Within the next year, we should make major inroads on curricular revision. The faculty is the only group really equipped to do this.

The problem of school finances is certainly in the category of the half-full/half-empty glass. The Medical Center is currently under a permanent rescission of 1%. Juggling of rescission amounts in some academic areas has resulted in our taking only half of a percent, an amount we can live with if additional cuts are not made. The annual increment in salary increases in July averaged only 2.5%. Some 29 states have experienced mid-year cuts in their budgets from 1 to 10%, with an average of 3.9%. The states around us have experienced cuts ranging from none (but with a tax increase) to 8%. (Oregon is experiencing a cut of up to 15%.) Maybe our half-percent isn't too bad.

When the Legislature found a sizeable amount of unused faculty salary dollars in unfilled faculty lines, I said I would try to put our funds to work so they wouldn't be at risk of being taken for use elsewhere. I accomplished this goal, but a tight economy has resulted in fewer people changing jobs, fewer empty lines and a marked decrease in shrinkage, which is a usual source of funds. Until some shrinkage accumulates, this is not a good time to approach the Dean's Office looking for funds. In the allocation of funds, it seems inevitable that some areas feel shorted. I suggest this is inevitable and will continue under whatever system we devise.

Space allocation is another commodity whose distribution leaves somebody unhappy. The soon-to-be-started research building should take some of the pressure off, but it must be kept in mind that the new building was approved by the Legislature only if part of it were paid for by *new* indirect dollars generated by *new* grant funding. That gives you a hint as to the likely key to laboratory space assignment.

While the mood of our faculty regarding finances produces more long than smiling faces, some figures show that perhaps our finances are not as bad as some of us have imagined:

- Between 1987-88 and 1989-90, state support increased 21% — from \$46,401,415 to \$56,295,779, about five times the inflation rate.
- Medical practice plan revenues went from \$43 million to almost \$50 million.
- Total federal grants went from \$9.5 million to \$12.7 million in the last two years.

The future is uncertain, but the Governor is supportive of higher education. And there is some indication that the resistance to a tax increase, to permit the updating of equipment, renovation of patient areas and becoming competitive in faculty salaries, is weakening.

Legislative pressures are a part of our daily lives, and I believe our legislators see the Medical Center's primary function as producing doctors and nurses for the state of Kansas. They recognize that there are important activities here to be proud of, but they do have difficulty justifying putting \$56 million of taxpayers' money into the school when all but a handful of counties are still classified as medically underserved. (Some legislators have wondered if the money might be more cost-effective if invested elsewhere — such as paying tuition for Kansas students to attend schools in other

states!) *What we must do is respond to their concerns by increasing the output of physicians of the type they want and by emphasizing that this school of medicine not only produces physicians but is also the home base for world-class scientists who conduct cutting-edge research in many areas — research that will ultimately benefit all people, including Kansans.* [Emphasis added. — Editor]

At the national level, consideration is being given to creating a differential in pass-through dollars which Medicare pays for housestaff in training. If reimbursement for housestaff in primary care disciplines is greater than for other disciplines, there will be a shift in that direction.

In meeting the directive of the Board of Regents to reformulate the missions of the respective schools, faculty input should keep in mind that specificity leads to limitations, and we risk painting ourselves into uncomfortable corners. In addition, any mission we assume will have to be judged as acceptable and affordable by the taxpayers (represented by the legislators) paying the bill.

In the time available, I cannot touch on every measurable parameter by which we might assess the condition of the school. For instance, the medical school in 1982 had 369 full-time faculty, three years ago 411, two years ago 445 and now 458 (not including the Wichita branch). Does this say the school is not an attractive place to work and the faculty are leaving in droves?

On a scale of 1 to 10, I'd place our School of Medicine at 8+. A year from today, I hope we all agree it's 9 or better.

REMINDER:
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LEGISLATURE APPROVES NEW PROGRAM

Reducing Pregnancies Among Minors

MICHAEL D. BROWN, R.N., M.S., Topeka

During the 1991 session, the Kansas Legislature passed a bill establishing a new youth pregnancy prevention program,¹ and on May 9 Governor Finney approved and signed the legislation. In September the program received first-year funding of \$100,000 to establish two local projects.

This program, which will be introduced first in Shawnee and Cowley counties, is based on a successful South Carolina model in which the pregnancy rate among girls aged 14 to 17 was reduced by 63% between 1982 and 1984. (Details of this program were published in *KANSAS MEDICINE* in March 1990.) The primary goal is that young people postpone their first sexual intercourse at least until they finish high school. A secondary goal is for those who do have intercourse either to stop until they finish high school or to practice effective contraception consistently.

According to the new law, the Secretary of the Kansas Department of Health and Environment (KDHE) will implement the program and its allocations. Local projects must have an advisory committee that includes health care professionals, and programs should consider involving parents, schools, churches, civic and youth groups, the mass media and other segments of their community.

KDHE data indicate that rural as well as urban counties have significant adolescent pregnancy problems.² During 1985–89, Seward County (population approximately 17,000) had the highest county pregnancy rate for the 15–19 age group. And in 1989, Ford County (population of about 24,000) had the highest county pregnancy rate for females in the same age group.

During 1990, Kansas girls age 17 or younger had 1,505 live births, including 199 second, third or fourth babies.² That year, minor females in the state had 14 stillbirths and 504 induced abortions, including 46 second or third induced abortions. In 1990, for the 31st year in a row, unmarried Kansas minors who had live births helped raise the percentage of out-of-wedlock births for

new mothers of all ages. In that year, the figure reached 21.4%. For one 1990 new-parent couple, both the mother and the father were 14 years of age or younger.

Kansas legislators were motivated by more than just compassion for the plight of these youngsters, however. Each year they allocate about \$150 million for Aid to Families with Dependent Children, Medicaid and food stamps to assist families begun when the mother was 19 or under.³ And state and local officials spend more of Kansas taxpayers' money on such families through child support collection, subsidized housing and child care, special education, employment and legal assistance and other expensive programs.⁴

In addition to the fiscal aspects, there are serious medical and social consequences related to this problem. Pregnancy among adolescents is widely associated with poverty, single parenthood, inadequate prenatal care, limited formal education, smoking, substance abuse, preterm delivery and low birthweight.^{2,5,6} Fortunately, though, two recent studies found that every dollar taxpayers spend on publicly funded contraceptive services saves taxpayers at least \$4.40 and as much as \$7.70 on Aid to Families with Dependent Children, food stamps, the WIC nutrition program and medical care.^{7,8}

In the Denmark, South Carolina project on which the new Kansas program is based, a health educator, a school nurse and the local public health department collaborated to achieve the reduction in their school-age pregnancy rate.⁹ An article on the program published in *JAMA* reported that drop is "statistically significant when compared with three sociodemographically similar counties."¹⁰

In Kansas, KDHE has awarded the new program's two first-year grants to urban Shawnee County, where the local YWCA and United Way Teen Pregnancy Coalition will administer the project; and rural Cowley County, where a non-profit organization, Families Actively Communicating Together, will run it. In these counties, local pediatricians, family practitioners and other interested physicians can help their local projects as advisory board members, concerned parents, interested church members or in other capacities.

Elsewhere in Kansas, physicians can network with other professionals and pertinent organizations to encourage their state senators and representatives to allocate more funds for this program during the upcoming legislative session so the

KDHE can expand this program to include other counties.

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Use of Chemotherapy in the Management of Advanced Head and Neck Cancers

P. G. SHANKAR GIRI, M.D.,* *Kansas City*

Advanced squamous-cell cancers of the head and neck are generally treated with a combination of surgery and radiation therapy (RT), as the results with either surgery or radiation therapy alone are poor in these large tumors. There is still a high incidence of local recurrence or persistence, and subsequent poor survival.^{1,2,3} Many patients are unresectable at diagnosis and may not be surgical candidates even after preoperative radiotherapy. There is therefore a need either to modify the existing modalities or to use other agents to achieve better local control and survival.

Chemotherapeutic agents, either singly or in combination, have been used extensively in recurrent head and neck tumors.^{4,5,6} Combination chemotherapy, especially those regimens using cisplatin, have produced high response rates.^{7,8,9,10} There is now a renewed interest in the use of chemotherapy along with surgery and/or radiation therapy in advanced head and neck tumors. Chemotherapy can be: neo-adjuvant chemotherapy prior to surgery and/or radiation therapy, as a cytoreductive measure; concurrent with radiation therapy; or postoperative/post-RT chemotherapy.

Neo-Adjuvant Chemotherapy

Surgery and radiation therapy cause alterations in vasculature of the tumor bed, which may prevent sufficient concentration of drugs from reaching the tumor. It is hoped that if chemotherapy is given prior to surgery or radiation therapy sufficient concentration of the drug will reach the tumor to produce tumoricidal effects. In addition, neo-adjuvant chemotherapy also allows for assessment of tumor response. While several drugs are known to have activity against squam-

ous-cell carcinomas of the head and neck, cisplatin probably has the highest activity. As a single agent, it has been shown to produce a 30 to 40% response rate.^{11,12} Very few are complete responses (CRs), however, and most are partial responses (PRs). In combination with other drugs such as Vinca alkaloids, bleomycin and 5-fluorouracil (5-FU), the overall response rates increase to 60 to 80%. The number of complete responses ranges from 25 to 35%.^{13,14,15,16} The combination of cisplatin and 5-FU has the highest activity in untreated advanced head and neck squamous cancer. A Wayne State University study using this combination reported an overall response rate of 93%, with a CR rate of 54%.^{17,18} But a subsequent multi-institutional trial conducted by the Radiation Therapy Oncology Group (RTOG) using the Wayne State pilot experience produced only a 38% CR rate.¹⁹

Table 1 lists some randomized trials comparing neo-adjuvant combination chemotherapy with standard treatment consisting of surgery and radiation therapy. The results show no survival benefit with the use of adjuvant chemotherapy, despite the high response rates. Due to their small numbers, all head and neck tumors are treated in a similar fashion without considering biological differences that may exist in the various anatomic sites. Other factors include the size and location of the primary tumor, status of lymph nodes, such as size, number, bilaterality and extracapsular extension, tumor differentiation and response to treatment. The various chemotherapeutic agents used also differed in not only the combination but also the dose and number of cycles used. Even within any given trial, it was not always possible to deliver all the prescribed cycles of chemotherapy in all the patients. In addition, the low CR rate in these trials may be another reason for the negative results.

Despite the overall low CR rates, patients who responded to chemotherapy fared better than the

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non-responders. Al-Kourainy, et al.²⁸ have reported that patients who achieved a pathological complete response (CR) to cisplatin and 5-FU chemotherapy had a significantly superior survival rate when compared to those who achieved a clinical CR but had residual microscopic disease. Another Wayne State University trial showed that three cycles of cisplatin and 5-FU chemotherapy produced a higher CR rate when compared to a single cycle.²⁹

The optimal number of chemotherapy cycles needed has not been adequately addressed. The Southwest Oncology Group is presently conducting a trial comparing three with six cycles of cisplatin and 5-FU chemotherapy to determine if giving six cycles increases the number of clinical and pathological CRs. Whether chemotherapy selects a group of patients whose tumors are also responsive to RT and would have responded even without chemotherapy is controversial.^{30,31} Ensley et al. concluded that 41 of 42 patients who had a PR to chemotherapy subsequently responded to radiation therapy, in contrast to only 1 of 18 non-responders.³²

It may be reasoned that response to chemotherapy may identify a group of patients who will benefit by the addition of RT. Ensley et al.,³³ using flow cytometry, have suggested that aneuploid tumors are responsive to both chemotherapy and RT, whereas diploid tumors are relatively resistant to the two modalities. The Southwest Oncology group is currently conducting a trial to verify the Wayne State findings. The concept of selecting patients who will respond to radiation therapy is very attractive. Several pilot studies indicate that this may be possible. Jacobs et al.³⁴ treated 30 patients with three cycles of cisplatin and 5-FU chemotherapy, followed by repeat endoscopy and biopsy. Twelve patients achieved a CR, and they were then treated with radiation

therapy. At 2 years they were relapse free, and overall survivals were 60% and 70%, as compared to 52% and 53% for the whole group.

The Veterans Administration (VA) Study Group recently completed a randomized study in advanced resectable laryngeal cancers. Patients were treated with two cycles of cisplatin and 5-FU before definitive treatment. Responders then received one additional cycle of chemotherapy followed by definitive radiation therapy. Surgery was used only as "salvage" in these patients. A preliminary report by the group has shown that at 2 years 50% of these patients did not need a laryngectomy.²⁴ These data suggest that in advanced resectable head and neck cancers preservation of anatomy and function may be possible in some selected sites without compromising local control or survival.

Concurrent Chemoradiotherapy

Chemotherapy administered concomitantly with radiation therapy has been used in several studies with encouraging results.^{35,36,37} Currently most of the interest is in combining cisplatin with radiation therapy. Apart from its effects on squamous-cell carcinomas, experimentally cisplatin acts as a radio-sensitizer by inhibiting repair of radiation-induced damage. It also makes hypoxic cells more sensitive to radiation.^{38,39,40,41} The optimal schedule for the drug and radiation, including the dose of cisplatin, the number of chemotherapy cycles and the total dose of radiation, has not been established. It appears that sensitization may be greatest if both cisplatin and RT are given concurrently, or if the RT is given within 24 hours following the administration of the drug.⁴²

The dose of cisplatin that needs to be used along with RT is not well understood. An Inter-group head and neck randomized trial in unresectable head and neck cancers compared stan-

TABLE 1
RANDOMIZED TRIALS OF INDUCTION CHEMOTHERAPY

Author	No. of Pts.	Chemotherapy	Response (%)		Survival Benefit
			Overall	(CR)	
Taylor	90	MTX	40	(6)	None
Holoye	83	B,CMF	72	(5)	None
Martin	107	CBM,5-FU	49	(6)	None
Schuller	158	CBV	70	(19)	None
Laramore	175	C,5-FU	98	(46)	None
Toohill	60	C,5-FU	85	(18)	None
Head & Neck Contracts	443	CB	37	(3)	None

MTX = Methotrexate, C = Cisplatin, 5-FU and F = 5-Fluorouracil, B = Bleomycin, V = Vincristine.

dard fraction RT with RT plus weekly 20 mg/M2 cisplatin chemotherapy.⁴³ In this study there was no difference between the two groups in either disease-free or overall survival. A study by the RTOG used a higher dose of cisplatin 100 mg/M2 given every three weeks concomitantly with radiation therapy. Preliminary results showed a CR rate of 72% with this combination.⁴⁴ The improved results may be due in part to enhancement of RT effects in addition to the tumoricidal effect of the drug itself. Further trials comparing this combination to standard RT alone are currently in progress.

The issue of whether to use sequential or concurrent chemotherapy also has not been answered in randomized trials. In a preliminary report of a randomized study comparing the two, an Italian study group reported that the concurrent arm resulted in statistically significant better results for local control compared to the sequential arm.⁴⁵ Caution must be exercised when planning these types of combinations, as the acute toxicity can be significant. In a study of preoperative chemoradiotherapy using cisplatin and 5-FU with RT, Adelstein et al. reported significant hematological and mucosal toxicity. Life-threatening myelosuppression occurred in 42% of their patients, with 18% requiring hospitalization. Severe mucositis occurred in all but three of their patients, with 21% being admitted to the hospital for treatment.⁴⁶

Postoperative Chemotherapy

The rationale for the use of postoperative or post-radiation chemotherapy is twofold. It is hoped that the addition of chemotherapy will improve local control when compared to that obtained with surgery, radiation therapy or a combination of both modalities. There is increasing evidence that in patients who achieve locoregional control there is a higher incidence of distant disease.^{47,48} The addition of chemotherapy might decrease the incidence of distant disease. There are three randomized studies that have evaluated the use of postoperative chemotherapy. Two of these studies did not show any benefit in either relapse-free or overall survival between the two groups.^{49,50} In the third study, Huang et al.⁵¹ compared 50 patients who received methotrexate, bleomycin, vinblastine and lomustine given after surgery and/or radiation therapy to 52 patients who were treated with surgery and/or radiation alone. Preliminary results revealed 36/50 (72%) of the adjuvant patients were disease-free, as compared to

30/52 (58%) who did not receive chemotherapy. In a retrospective comparison of patients entered on Southwest Oncology Group induction chemotherapy trials, Schuller et al.⁵² reported a statistically significant decrease in the incidence of distant metastasis in patients who received postoperative chemotherapy. Similar results have been reported by Ervin et al.⁵³ and The Head and Neck Contracts study,²⁷ where patients received both pre- and postoperative chemotherapy. There is currently an ongoing Intergroup trial in resectable head and neck cancers where patients are randomized after surgery to receive either postoperative radiotherapy or three cycles of cisplatin and 5-FU, followed by radiotherapy. There is also an ongoing Intergroup nasopharynx trial comparing standard radiotherapy to concurrent cisplatin and radiation therapy, followed by three cycles of cisplatin and 5-FU chemotherapy. Thus the role of post-surgery radiation therapy/chemotherapy is at present still under investigation.

In conclusion, various treatment strategies using different chemotherapeutic agents have been under investigation for over 10 years. Although several studies suggest possible benefits from the use of chemotherapy, the combination of drugs and the best schedule to use have not been established. The ongoing studies will perhaps better define their use. There is a need to develop new chemotherapeutic agents or combinations that will yield higher CR rates. Research must be directed towards identifying factors that will predict chemotherapy responsiveness of tumors. The use of concurrent chemo-radiotherapy may result in higher local control rates when compared to RT alone. Neo-adjuvant chemotherapy with radiation therapy for the responders is another possible approach that should be explored. At the present time, there is no conclusive evidence to support the routine use of postoperative chemotherapy.

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(Continued on page 316.)

THE WAY IT WAS

(From the Journal of the Kansas Medical Society, June 1919. In 1912, the KMS established the Physicians' Indemnity Association. This was administered by the Medical Defense Board, consisting of three members of the Society and the legal representative, a lawyer by the name of Edwin D. McKeever. The following is a condensation of his report at the annual meeting, held in Ottawa that year.)

Gentlemen: Since my last report I have tried one case — the case of Paulich vs. Nipple in Crawford County. This suit had been once tried without my assistance and resulted in a hung jury. Dr. Nipple's local attorneys advised him to settle for \$750. In keeping with the spirit of our members not to settle anything, he declined to settle and asked me to defend him, which was extremely satisfactory to his local counsel. I tried this case and Judge Curran, at the close of the plaintiff's evidence, sustained my demurrer and rendered judgment for Dr. Nipple. Later, without any notice to me, Judge Curran set aside his judgment and granted a new trial, from which I appealed to the Supreme Court. The case was argued at the April term, and will be decided in a few days.

The case of McRoberts vs. Clopper in Wyandotte County has been dismissed. The plaintiff made an offer to dismiss this on a settlement of \$50. Dr. Clopper very properly refused to purchase the dismissal of this suit and also stood ready for trial, and the case was dismissed at the plaintiff's cost.

This illustrates the importance of standing pat in these cases and I recommend to the members of the profession that they follow the policy of Drs. Nipple and Clopper, and not get panicky and settle these cases — at least not without the consent of counsel. Many cases are brought with no intention of trying them, with the expectation that the doctor will get scared and settle them.

Your attorney for the first time since his connection with your defense board has settled a case. I have always had a fear of cases where the surgeon became so absorbed in the operation that he sewed up a sponge or piece of gauze in his patient. There appears to be a good many cases of this kind in the law reports and generally there is not a chance to defend against them.

I had a case of a member who in some way left inside the bowels of a patient a piece of gauze 16 × 14 inches long with a metal ring on the end. The patient afterwards had an operation and died. This looked like a good case to settle, both from a legal and moral standpoint, and when the bereaved husband agreed to settle for his expenses of \$1000, I lost no time in paying it in behalf of the Physicians' Indemnity Association in which the physician was insured.

(Here follow brief summaries of some 13 cases pending, some inactive as the physician was in the service, or the plaintiffs had not pursued the matter.)

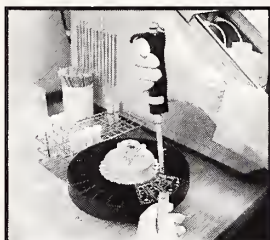
As I am the father of the Physicians' Indemnity Association, I will be pardoned for again referring with pride to this institution. This association has grown steadily and in addition has been admitted to four other states, which place it on an equal basis with the best indemnity companies. The same high requirements are made as to membership in the other states as in this state, and no person can become a member who is not eligible to membership in his State Society. There is a surplus in the treasury of over \$10,000, and one case pending which is wholly without merit and which will probably never be tried. We have made one settlement in which we paid \$1,041 to avoid a certain loss.

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The admission of our association to the states of Iowa, Nebraska, Missouri and Oklahoma will insure a large and rapid growth, which will still further establish the association as a bulwark of efficient and complete protection against loss or expense, that may occur on account of malpractice suits.

(Mr. McKeever's personal expenses for the year, fees and per diems, came to \$690.41.)

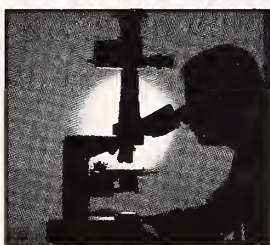
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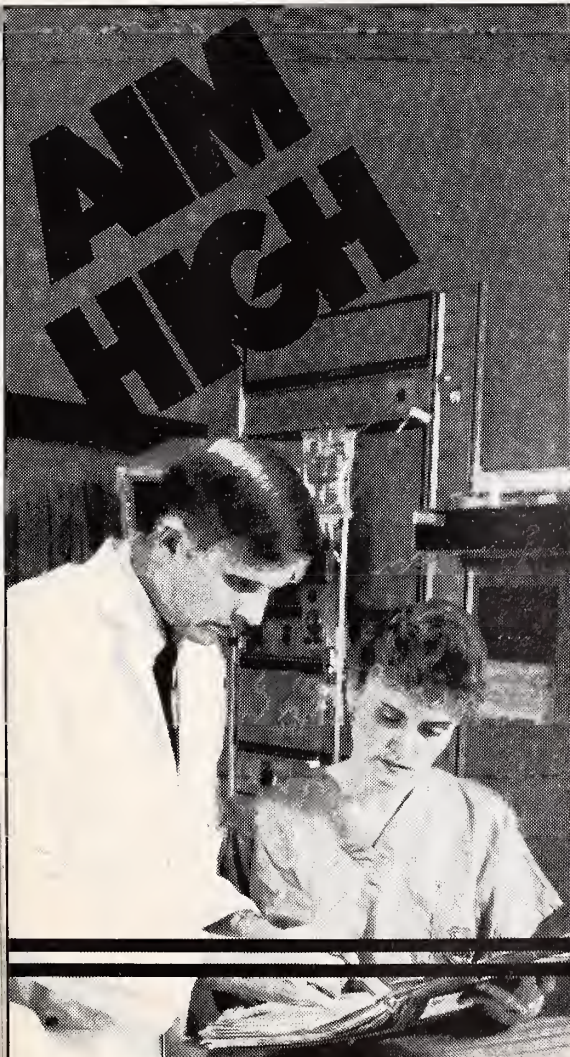
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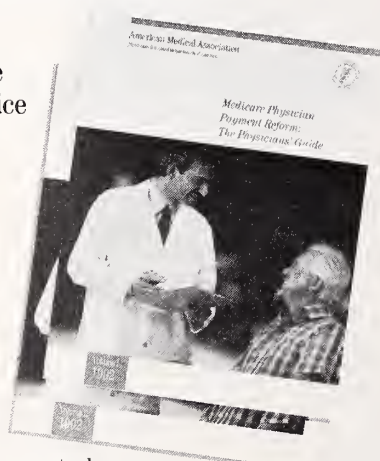
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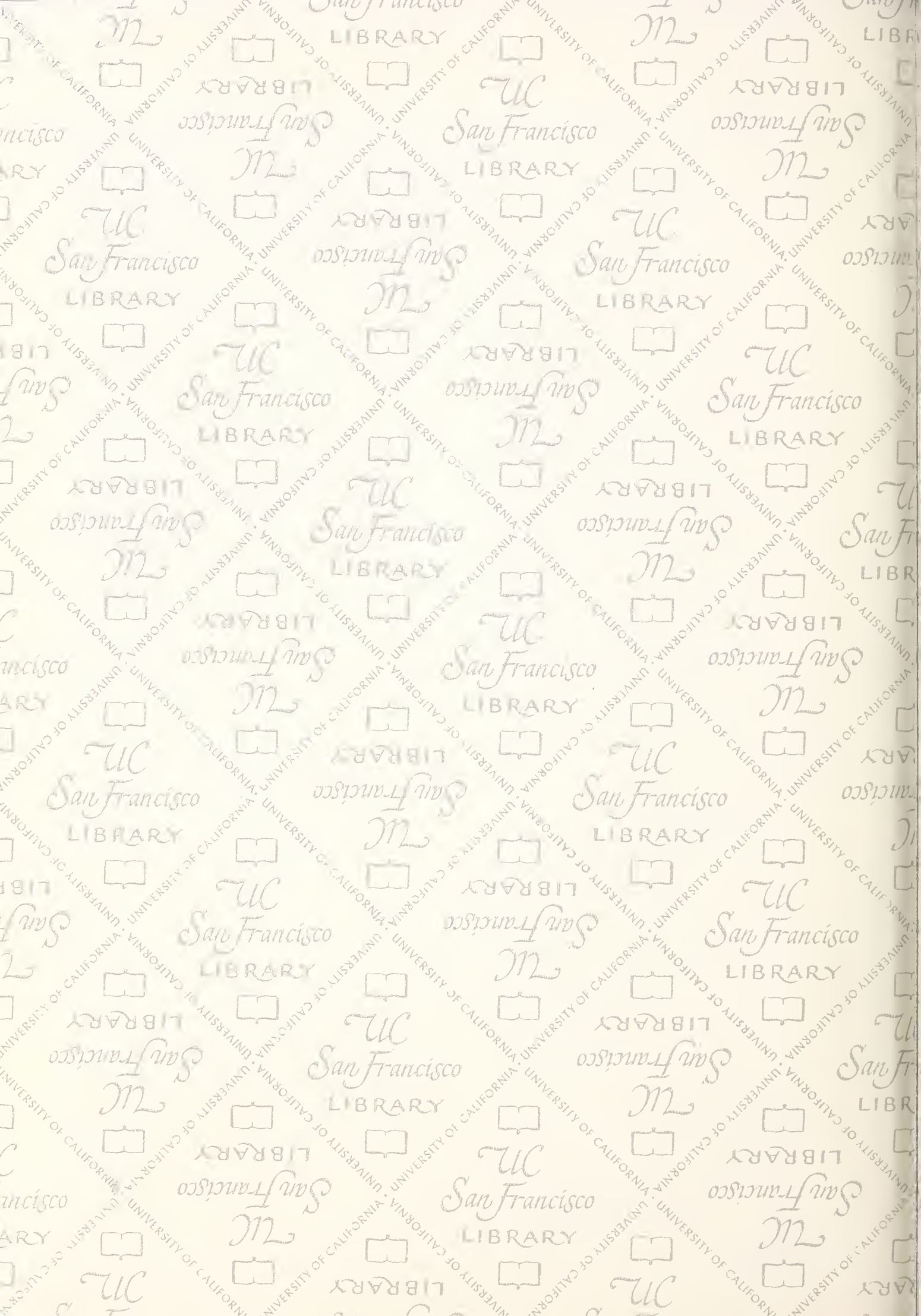
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